STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMILY P. BISSELL HOSPITAL	3000 NEWPORT GAP PIKE WILMINGTON, DE 19808

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 1, 2012 through October 12, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 63. The Stage 2 sample totaled thirty-nine (39) residents which included a review of one (1) closed record.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to	F 156		

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

HOSPITAL DIRECTOR 11-15-12

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that er safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days owing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 's following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued gram participation.

JOHN S. OPPENHEIMER
DHA H10000388 KE

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F 156	Continued From page 1 the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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F 156	Continued From page 2 facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and review of Resident Council Minutes, it was determined that the facility failed to ensure that the staff discussed and reviewed the rights of residents in the facility. Findings include: An interview with R30 (Resident Council	F 156	(a) Immediate Corrective Action: Resident Rights, Care Section, were reviewed at the Resident Council meeting at 10/15/12. (b) Identifying other Residents having the potential to be affected: All residents have the potential to be affected by this deficiency. (c) Systemic Response: One Section of the Residents Rights Pamphlet will be covered at each Resident Council meeting. Copies of the Resident Rights are posted in the facility. Pamphlets are available in English and Spanish in on the entrance ramp and from Social Services. (d) Monitoring: Minutes taken at the Resident Council meeting will reflect review of Resident Rights on a monthly basis.	10/15/12 10/15/12 10/15/12

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F 156	Continued From page 3 President) on 10/2/12, revealed that the staff did not discuss and review the rights of the residents. Review of the Resident Council meeting minutes for 4/12, 8/12 and 9/12 lacked documented evidence that the staff discussed and reviewed the rights of residents in the facility in a language that the residents understood during their stay in the facility.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157		

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F 157	Continued From page 4 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that an interested family member was immediately informed of one (R4) out of 39 Stage 2 sampled residents of significant changes in this resident's health status and to commence new forms of treatment to deal with the problems. Findings include: According to R4's Minimum Data Set (MDS) assessment, dated 8/13/2012, R4 had severely impaired cognitive skills for daily decision-making. R4 was totally dependent of staff for all ADLs (activities of daily living) such as bed mobility, transfer, bathing, dressing and personal hygiene. Her prescribed medications included an anti-anxiety and an anticoagulant drug. R4 was also on a Restorative Nursing program. The facility initiated a care plan entitled, "General Care Needs", last reviewed on 08-14-2012 had the goal that (Name of Resident) and her daughter will receive services as needed or requested. The care plan approaches included: ... will maintain contact with (Resident's name) daughter to encourage open communication and obtain necessary consents as requested by the doctor.	F 157	(a) Immediate Corrective Action: Immediate corrective action was taken by removing (E34) from direct resident care pending outcome of the investigation. An incident report was completed and reported to the Division of Long Term Care Resident Protection (DLTRCP) on 05/20/11. It is the policy of this facility to thoroughly Investigate and report all allegations of verbal, mental, physical or sexual abuse. The incident was thoroughly investigated and appropriate disciplinary action was administered. Staff received reminders to respect resident's right to privacy and to explain procedure to the resident prior to providing care. Staff involved with this incident no longer work at Emily P. Bissell Hospital. (b) Identifying other Residents having the to be affected: All residents have the potential to be affected by the cited deficient practice. (c) Systemic Response: A notification of changes in resident's health status policy was developed on 11/05/12, and will be initiated after staff training is completed by 11/30/12. All Licensed Staff will receive focus training regarding the importance of notifying interested family members, legal representatives / responsible parties, and physician of significant changes in resident's health status by staff development and nursing supervisors. *(See attachment "A").*	10/17/12 11/30/12

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F 157	Continued From page 5 Review of R4's record revealed the following sequence of events: A nurse's note dated 9/21/12 (0500) stated..."While CNA was providing care to resident she observed a skin abrasion to right abdominal fold and reported it to this nurse". A "7.5 cm skin abrasion noted....will call daughter" A nurse's note, dated 9/21/12 stated, "MD assess scratch found from 11-7 shift. New order written - R (right) flank abrasion cleansed with saline bacitracin dsd (dried sterile dressing) BID until healed". There was no documentation and/or follow up note to indicate that the interested family member was notified. Additionally, a nurse's note dated 9/22/12 stated, "Resident was observed coughing this AM. Resident has a standing order 1-2. Nursing gave Robitussin as per MD ordered for cough @1015. Nursing will monitor for results". A nurse's note dated 9/23/12 stated, "Resident also observed with occasional wet non-productive cough. Medicated with Robitussin 2 tsp at 0545. Results pending." A nurse's note dated 9/23/12 (2145/ 9:45 PM) stated, "Robitussin 10 ml given at 2130 (9:30PM) due to amount of coughing..." Thick yellow sputum was removed from R4's mouth. A nurse's note dated 9/24/12 0630 (6:30 AM) stated, "continues with wet cough".	F 157 157 continued (d) Monitoring	All changes in resident's health status will be placed on the daily report sheet and the 24 hour supervisor's report. Nursing Supervisors and Unit Managers will perform random spot to ensure that family notification was documented in resident's clinical record. Any concerns will be addressed by Nursing Supervisors and reported to ADON or DON for corrective action.	11/30/12 and ongoing

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F 157	Continued From page 6 A nurse's note dated 9/26/12 stated, "Wet cough noted. Medicated at 0430 (4:30 AM) with Robitussin." A nurse's note dated 9/26/12 stated, "MD ordered Robitussin DM 2 tsp q (every) 6 hr. PRN (as needed for) cough. MD stated that he didn't want a stop date". A nurse's note dated 9/27/12 0640 (6:40 am) stated .."deep wet frequent cough. Medicated at 0100 (1:00 AM) with 2 tsp. Robitussin DM via g (stomach) tube". A nurse's note dated 9/28/12 0455 (4:55 am) stated, "Coughing wet productive cough at beginning of shift. Medicated with Robitussin DM at 0030 (12:30 AM)". 9/28/12 - New MD order for "Nasal Cannula only (oxygen administered by nasal cannula). V/S (vital signs)". Review of the clinical record lacked documented evidence that the interested family member was notified. The facility failed to ensure that the interested family was informed of R4's change in health status and treatments being provided. On 10/12/2012 at 10:40 AM, E6 (RN) confirmed the findings.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by	F 167		

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F 167	Continued From page 7 Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and review of the Resident's Bill of Rights, it was determined that the facility failed to post the results of the most recent survey. Findings include: According to the facility's "Access to Information section of the Resident's Bill of Rights", a resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors, and any plan of correction in effect with respect to the facility. On 10/10/12 at 11 AM, observations of the day rooms on Main 3 and Main 2 revealed that the most recent survey results were not posted and available to residents, families and visitors. The books had the federal and state surveys for 2008 and 2009, but failed to contain the 2011 annual survey results. The facility failed to have the most recent survey in the survey books available to residents, visitors and families. On 10/10/2012 at 11:10 AM in an interview, E3 (Director of Nursing) confirmed that the most recent survey results were not posted in	F 167	(a) Immediate Correction Action: Survey results from 2010 and 2011 were placed in designated areas. (b) Identifying other residents having the potential be affected: All Residents have the potential to be affected by this deficiency. (c) Systemic Response: The Administrative Specialist II to the Facility Director will be responsible for placing most recent survey results in designated areas. (d) Monitoring: The Social Services Administrator will do quarterly checks to ensure that the last three(3) years survey results are available in designated areas.	10/12/12 10/12/12 11/7/12

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F 167	Continued From page 8 the day rooms.	F 167		
F 223 SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on record review, review of other facility documents and interview, it was determined that the facility failed to ensure that one (1) resident (R64) was free from sexual abuse by a facility staff. Findings include: R64 had active diagnoses of PVD (peripheral vascular disease), Hyperlipidemia (high cholesterol), right CVA (stroke), Hemiplegia (limitation of range of motion on right upper and lower extremities) anxiety, depression, psychotic disorder, COPD (chronic obstructive pulmonary disease) osteoarthritis and chronic pain syndrome. According to R64's Minimum Data Set (MDS) assessment dated 9/26/12, this resident's cognitive skills for daily decision-making were independent. He needed oversight supervision/limited assistance of staff with his ADL (activities of daily living) function. R64 used an electric wheelchair for mobility device. R64 was receiving antipsychotic, anti-anxiety,	F 223		

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F 223	Continued From page 9 antidepressant, and anticoagulant medications. R64 was continent of bladder function and used the urinal when in bed. Review of E42's (Psychiatrist) consult note regarding depression, dated 5/30/11, stated that R64 "had a problematic interaction with staff of the facility ...complaint of sexual molestation. Now ADL's done by 2 members of RN (Registered Nurse) staff to insure safety". According to the facility's incident report dated 5/20/11, "Resident alleges that (date unknown) in the past few weeks, (time unknown), a male CNA, E 34, "groped him and inappropriately touched his penis". The facility's result of the investigation for this allegation, dated 5/20/11 at 1930 hrs. (7:30 PM) stated, "Investigation revealed the accused (E34) was checking the resident for wetness while trying not to disturb his sleep by touching the outside of his diaper". A written statement from the accused E34 (CNA), (date unknown), stated, "RN instructed me....by the end of the shift (3-11 PM shift) I should make sure that his (R64's) bed pad was not wet since he uses a urinal..." In an Interview with R64 on 10/10/12 at 2:45 PM, he stated that during that time, he was asleep and woke up suddenly when he felt someone was touching him. In an interview with E33 (CNA) on 10/10/12 at 2:30 PM, she stated that before she would provide care to a sleeping resident, she would try	F 223		
		(a) Immediate Corrective Action	Immediate corrective action was taken by removing (E34) from direct resident care pending outcome of the investigation. An incident report was completed and reported to the Division of Long Term Care Resident Protection (DLTRCP) on 05/20/11. It is the policy of this facility to thoroughly investigate and report all allegations of verbal, mental, physical or sexual abuse. The incident was thoroughly investigated and appropriate disciplinary action was administered. Staff received reminders to respect resident's right to privacy and to explain procedure to the resident prior to providing care. Staff involved with this incident no longer work at Emily P. Bissell Hospital.	10/17/12
		(b) Identifying other Residents having the to be affected	All Residents have the potential to be affected by this practice.	
		(c) Systemic Response	All staff will be in-serviced on the Dignity and Quality of Life Policy, with emphasis on respect for resident's private space and respectfully communicating with resident prior to providing care or service ***(See attachment B).***	11/30/12
		(d) Monitoring	Nursing Supervisors and Unit Managers will monitor compliance through daily observation during floor rounds. Any concerns will be addressed by Nursing Supervisors and reported to ADON or DON for corrective action.	11/30/12 and ongoing

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F 223	Continued From page 10 to wake up the resident first and let the resident know what care she was about to provide. According to E3 (DON) on 10/10/12, E34 (CNA) no longer worked in the facility.	F 223		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225		

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K F225	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

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F 225	Continued From page 11 with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to thoroughly investigate an alleged incident of abuse for one (R14) out of 39 Stage 2 sample residents. Findings include: On 10/3/12 at 9:01 AM during an interview, R14 relayed an allegation of physical abuse during incontinence care on the evening shift which had occurred about 3 weeks ago. R14 agreed to tell this information to E4 (Unit Manager/Charge Nurse), which she did on 10/3/12 at 9:40 AM. Review of the Incident Report revealed that the report was submitted to the state on 10/3/12 at 3:41 PM with the incident type noted as "Abuse". The "Employee Interview Statement" was completed by E4. It noted that E4, "Interviewed (the resident's) primary care CNA on 7-3, and all the 7-3 nurses on duty on M3 (Main 3) today which consists of the regular 7-3 nursing staff, none of them reported ..." The "Employee Interview Statement" did not list names of those interviewed during the 7-3 shift. There were no statements from CNAs (other than the accused, E32, in an interview) and Nurses on 3 -11 shift or 11 - 7 shift. The allegation stated that the alleged abuse occurred on the 3 -11 shift.	F 225	(a) Immediate Corrective Action: Statements were obtained by 3 PM to 11 PM shift for incident involvingR4 reported on 10/3/12 LTCP conducted a separate investigation using same documents collected by the facility and found the allegation unsubstantiated. (See attached)	11/9/12
			(b) Identifying other residents having the potential to be affected: All Residents are at risk when an investigation fails to interview all shifts or is incomplete.	11/13/12
			(c) Systemic Response: Investigative procedure developed (see attachment). Supervisors trained on protocol.	11/23/12
			(d) Monitoring: QA Nurse, Director of Nursing, Hospital Administrator and Director to review investigation prior to signature to ensure thorough investigation was conducted of each incident.	11/26/12

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F 225	Continued From page 12 On 10/11/12 at 9:15 AM, a request was made to review the 5 day Follow Up Incident Report and the investigation which E3 (DON) provided about an hour later. There were no further interviews or witness statements provided by E3. The facility failed to thoroughly investigate an alleged incident of abuse for R14.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to promote care for 18 (R9, R14, R15, R16, R18, R19, R27, R32, R34, R35, R39, R41, R45, R47, R52, R53, R65, and R67) out of 39 stage 2 sampled residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include: 1a. On 10/1/12, observation of the midday meal was conducted. R15 was observed seated at a table with R33, R52 and R65. At 11:35 AM, R33 was observed being fed by E31 (nurse). R15 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. 1b. On 10/8/12 at 8:00 AM, R15 was observed	F 241	Nursing 241- 1 (a) (a) Immediate Correction Action Immediate corrective action was taken to remind staff that all residents sitting in the same dining area are to be fed at the same time. One resident should not be eating, while other residents are sitting at the table waiting on meal trays to be delivered at a later time. *(E31)* Received reminders on providing care for residents in an environment that maintained or enhanced resident's dignity. (b) Identifying other Residents having potential to be affected All residents have the potential to be affected by these deficient practices.	10/1/12 10/2/12

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F 225	Continued From page 12 On 10/11/12 at 9:15 AM, a request was made to review the 5 day Follow Up Incident Report and the investigation which E3 (DON) provided about an hour later. There were no further interviews or witness statements provided by E3. The facility failed to thoroughly investigate an alleged incident of abuse for R14.	F 225		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined that the facility failed to promote care for 18 (R9, R14, R15, R16, R18, R19, R27, R32, R34, R35, R39, R41, R45, R47, R52, R53, R65, and R67) out of 39 stage 2 sampled residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include: 1a. On 10/1/12, observation of the midday meal was conducted. R15 was observed seated at a table with R33, R52 and R65. At 11:35 AM, R33 was observed being fed by E31 (nurse). R15 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. 1b. On 10/8/12 at 8:00 AM, R15 was observed	F 241 (a) Immediate Correction Action (b) Identifying other Residents having potential to be affected	Dietary 241 – 1b,2b,4a,b,c,5,6a,7,8,9,10,11, 12,13,14,15 Initial findings were assumed to be one time occurrence due to staff not having access to inventory. Additional stock was put into use. However after reviewing the exit findings, multiple dates and meals were included. Metal utensils were ordered and received to address the shortage of metal utensils. Staff was informed not to substitute metal utensils with plastic. Sweep was conducted of Resident rooms to gather utensils being stored by Residents. A review of care plans found that one Resident noted by surveyor R39 was care planned for plastic ware. Unable to determine 8 other Residents noted because the Residents were not identified on the sample list provided by surveyor. All Residents have the potential to be affected the use of plastic ware used for the dining experience.	10/25/12 10/25/12

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F 241	Continued From page 13 eating breakfast in the dining area using disposable plastic spoons (2). The facility failed to promote care for R15 in a dignified manner during dining. 2a. On 10/1/12, observation of the midday meal was conducted. R52 was observed seated at a table with R33, R15 and R65. At 11:35 AM, R33 was observed being fed by E31 (nurse). R52 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. 2b. On 10/8/12 at 8:00 AM, R52 was observed being fed breakfast in the dining area. Staff were using a disposable plastic spoon to feed R52. The facility failed to promote care for R52 in a dignified manner during dining. 3. On 10/1/12, observation of the midday meal was conducted. R65 was observed seated at a table with R33, R15 and R52. At 11:35 AM, R33 was observed being fed by E31 (nurse). R65 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. The facility failed to promote care for R65 in a dignified manner during dining. During an interview with E31 on 10/2/12 at approximately 12:00 PM, E31 was asked why R33 was fed his midday meal earlier than other residents? E31 stated that R33 would at times take a very long time to feed so he gets an early tray and is started to be fed before others. 4a. On 10/1/12 at 11:30 AM, R16 was observed	F 241 Nursing 241- 1 (a)	1(a) continued (c) Systemic Response A new Dignity and Quality of Life Policy was developed and approved on 11/05/12. Training will be provided by staff development and nursing supervisors to all nursing staff regarding new policy. Training will focus on resident's dining experience. Maintaining resident's dignity while feeding (use of regular silverwares for dining, instead of disposable plastic utensils); not standing over residents while feeding, and knocking on resident doors and waiting for response before entering resident rooms. *(See Attachment B)* (d) Monitoring Nursing Supervisors, Infection Control nurse, Nurse managers, staff development, Care Plan Coordinator, and Charge Nurses will monitor compliance through daily observation. The resident Dining Experience Feedback Tool will be utilized to identify any further concerns *(See Attachment C)*	12/15/12 12/15/12

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F 241	Continued From page 13 eating breakfast in the dining area using disposable plastic spoons (2). The facility failed to promote care for R15 in a dignified manner during dining. 2a. On 10/1/12, observation of the midday meal was conducted. R52 was observed seated at a table with R33, R15 and R65. At 11:35 AM, R33 was observed being fed by E31 (nurse). R52 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. 2b. On 10/8/12 at 8:00 AM, R52 was observed being fed breakfast in the dining area. Staff were using a disposable plastic spoon to feed R52. The facility failed to promote care for R52 in a dignified manner during dining. 3. On 10/1/12, observation of the midday meal was conducted. R65 was observed seated at a table with R33, R15 and R52. At 11:35 AM, R33 was observed being fed by E31 (nurse). R65 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. The facility failed to promote care for R65 in a dignified manner during dining. During an interview with E31 on 10/2/12 at approximately 12:00 PM, E31 was asked why R33 was fed his midday meal earlier than other residents? E31 stated that R33 would at times take a very long time to feed so he gets an early tray and is started to be fed before others. 4a. On 10/1/12 at 11:30 AM, R16 was observed	F 241	Dietary 241 – 1b,2b,4a,b,c,5,6a,7,8,9,10,11, 12,13,14,15 continued (c) Systemic Response Metal utensils will be stored in the kitchen area and accessible by all staff. Nursing is conducting a weekly roundup of utensils left on the units and returning them to the kitchen. Par levels were established and will be maintained to ensure adequate stock is in house at all times. Policy was developed against the use of plastic ware unless care planned for the resident. (See attached policy) Training was completed for all dietary staff and will be conducted for new hires and annually on this topic. Nursing staff to be trained on dining experience and reporting use of plastic ware and requesting replacements. 11/9/12 (d) Monitoring Cook Supervisor or Food Service Director will observe tray line daily to ensure use of plastic or paper goods is not being used. Nursing staff will report any paper products or plastic ware sent to the floor for a resident not care planned for same at the time of the event to request acceptable replacement items are brought up immediately. Any need to use paper or plastic ware will only be approved by Facility Director designee in an emergency basis such as power failure or water shut off. Periodic checks by the Hospital Administrator will occur on the units. All deficiencies will be reported to Food Service Director who will follow up with the individual responsible per the disciplinary process if appropriate. 11/12/12	

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F 241	Continued From page 13 eating breakfast in the dining area using disposable plastic spoons (2). The facility failed to promote care for R15 in a dignified manner during dining. 2a. On 10/1/12, observation of the midday meal was conducted. R52 was observed seated at a table with R33, R15 and R65. At 11:35 AM, R33 was observed being fed by E31 (nurse). R52 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. 2b. On 10/8/12 at 8:00 AM, R52 was observed being fed breakfast in the dining area. Staff were using a disposable plastic spoon to feed R52. The facility failed to promote care for R52 in a dignified manner during dining. 3. On 10/1/12, observation of the midday meal was conducted. R65 was observed seated at a table with R33, R15 and R52. At 11:35 AM, R33 was observed being fed by E31 (nurse). R65 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. The facility failed to promote care for R65 in a dignified manner during dining. During an interview with E31 on 10/2/12 at approximately 12:00 PM, E31 was asked why R33 was fed his midday meal earlier than other residents? E31 stated that R33 would at times take a very long time to feed so he gets an early tray and is started to be fed before others. 4a. On 10/1/12 at 11:30 AM, R16 was observed	F 241	# 2a (a) Immediate Correction Action Immediate corrective action was taken to remind staff that all residents sitting in the same dining area are to be fed at the same time. One resident should not be eating, while other residents are sitting at the table waiting on meal trays to be delivered at a later time. ***(E31)*** Received reminders on providing care for residents in an environment that maintained or enhanced resident's dignity. (b) Identifying other Residents having potential to be affected All residents have the potential to be affected by these deficient practices. (c) Systemic Response A new Dignity and Quality of Life Policy was developed and approved on 11/05/12. Training will be provided by staff development and nursing supervisors to all nursing staff regarding new policy. Training will focus on resident's dining experience. Maintaining resident's dignity while feeding (use of regular silverwares for dining, instead of disposable plastic utensils); not standing over residents while feeding, and knocking on resident doors and waiting for response before entering resident rooms. ***(See Attachment B)*** (d) Monitoring Nursing Supervisors, Infection Control nurse, Nurse managers, staff development, Care Plan Coordinator, and Charge Nurses will nonitor compliance through daily observation. The resident Dining Experience Feedback Tool will be utilized to identify any further concerns ***(See Attachment D)***	10/1/12 12/15/12 12/15/12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	Continued From page 13 eating breakfast in the dining area using disposable plastic spoons (2). The facility failed to promote care for R15 in a dignified manner during dining. 2a. On 10/1/12, observation of the midday meal was conducted. R52 was observed seated at a table with R33, R15 and R65. At 11:35 AM, R33 was observed being fed by E31 (nurse). R52 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. 2b. On 10/8/12 at 8:00 AM, R52 was observed being fed breakfast in the dining area. Staff were using a disposable plastic spoon to feed R52. The facility failed to promote care for R52 in a dignified manner during dining. 3. On 10/1/12, observation of the midday meal was conducted. R65 was observed seated at a table with R33, R15 and R52. At 11:35 AM, R33 was observed being fed by E31 (nurse). R65 sat and watched R33 being fed and was not served her meal until 11:55 AM, a total of 20 minutes later. The facility failed to promote care for R65 in a dignified manner during dining. During an interview with E31 on 10/2/12 at approximately 12:00 PM, E31 was asked why R33 was fed his midday meal earlier than other residents? E31 stated that R33 would at times take a very long time to feed so he gets an early tray and is started to be fed before others. 4a. On 10/1/12 at 11:30 AM, R16 was observed	F 241	F241 #3 (a) Immediate Correction Action	Staff received reminders regarding the importance of providing care in a dignify manner during dining. All residents sitting in the same dining area should be fed at the same time. *(E31)* Received reminders on providing care for residents in an environment that maintained or enhanced resident's dignity.	10/1/12
			(b) Identifying other Residents having potential to be affected	All residents have the potential to be affected by these deficient practices.	
			(c) Systemic Response	A new Dignity and Quality of Life Policy was developed and approved on 11/05/12. Training will be provided by staff development and nursing supervisors to all nursing staff regarding new policy. Training will focus on resident's dining experience. Maintaining resident's dignity while feeding (use of regular silverwares for dining, instead of disposable plastic utensils); not standing over residents while feeding, and knocking on resident doors and waiting for response before entering resident rooms. *(See* **Attachment B)**	12/15/12
			(d) Monitoring	Nursing Supervisors, Infection Control nurse, Nurse managers, staff development, Care Plan Coordinator, and Charge Nurses will nonitor compliance through daily observation. The resident Dining Experience Feedback Tool will be utilized to identify any further concerns *(See* **Attachment C)**	12/15/12

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F 241	Continued From page 14 eating his midday meal in the dining area with disposable plastic utensils (spoon, fork and knife). 4b. On 10/2/12 at 12:00 PM, R16 was observed eating his midday meal in the dining area with disposable plastic utensils (spoon, fork and knife). 4c. On 10/8/12 at 8:00 AM, R16 was observed eating his morning meal in his room with disposable plastic utensils (spoon, fork and knife). 4d. On 10/8/12 at 11:53 AM, R16 was observed eating his midday meal in the dining area with disposable plastic utensils (spoon, fork and knife). The facility failed to promote care for R16 in a dignified manner during dining. 5. On 10/1/12 at 12:00 PM, R39's tray was observed upon delivery to the unit. The tray contained disposable plastic utensils (spoon, fork and knife) instead of silverware. The facility failed to promote care for R39 in a dignified manner during dining. 6a. On 10/1/12 at 12:00 PM, R45's tray was observed upon delivery to the unit. The tray contained disposable plastic utensils (spoon, fork and knife) instead of silverware. 6b. On 10/8/12 at 12:05 PM, R45 was observed eating in her room using a disposable plastic spoon. R45 did have a regular (non-disposable silverware) fork and knife. The facility failed to	F 241		

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F 241	Continued From page 15 promote care for R45 in a dignified manner during dining. 7. On 10/1/12 at 12:00 PM, R35's tray was observed upon delivery to the unit. The tray contained disposable plastic utensils (spoon, fork and knife) instead of silverware. The facility failed to promote care for R35 in a dignified manner during dining. 8. On 10/8/12 at 8:00 AM, R19 was observed eating breakfast in the dining area using a disposable plastic spoon and fork. The facility failed to promote care for R19 in a dignified manner during dining. 9. On 10/8/12 at 8:00 AM, R32 was observed eating breakfast in the dining area using a disposable plastic spoon and fork. The facility failed to promote care for R32 in a dignified manner during dining. 10. On 10/8/12 at 8:00 AM, R14 was observed eating breakfast in the dining area using disposable plastic spoons (2). The facility failed to promote care for R14 in a dignified manner during dining. On 10/3/12 at 9:45 AM, E7 (LPN) knocked and entered R14's room without asking for permission to enter while E4 (RN UM/ charge nurse) and the surveyor were speaking to the resident. E7 stated that she was looking for another nurse. On 10/3/12 at 9:53 AM, E38 (Housekeeper) entered R14's room after the surveyor and E4 exited. E38 entered the room without knocking and without asking for permission to enter. When	F 241 Nursing 241 10 & 16 (a) Immediate Corrective Action (b) Identifying other residents having the potential to be affected	Upon notification of incident, ***(E16) (E7)and (E17)*** received reminders to respect residents right to privacy regarding knocking on resident's doors and waiting for response before entering resident rooms. All residents have the potential to be affected by these deficient practices.	10/3/12

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F 241	Continued From page 16 E4 addressed this with E38 in the surveyor's presence, E38 stated that the resident was facing him so he entered. 11. On 10/8/12 at 8:00 AM, R9 was observed eating breakfast in the dining area using a disposable plastic spoon. R9 did have a regular (non-disposable silverware) fork and knife. The facility failed to promote care for R9 in a dignified manner during dining. 12. On 10/8/12 at 8:00 AM, R47 was observed eating breakfast in the dining area using a disposable plastic spoon. R47 did have a regular (non-disposable silverware) fork and knife. The facility failed to promote care for R47 in a dignified manner during dining. 13. On 10/8/12 at 8:05 AM, R27 was observed eating breakfast in the dining area using a disposable plastic spoon, fork and knife. The facility failed to promote care for R27 in a dignified manner during dining. 14. On 10/8/12 at 12:05 PM, R18 was observed eating in his room using a disposable plastic spoon. R18 did have a regular (non-disposable silverware) fork and knife. The facility failed to promote care for R18 in a dignified manner during dining. 15. On 10/8/12 at 12:05 PM, R53 was observed eating in his room using a disposable plastic spoon. R53 did have a regular (non-disposable silverware) fork and knife. The facility failed to promote care for R53 in a dignified manner during dining.	Nursing 241 10 & 16 Continued F 241 (c) Systemic Response	For Nursing staff a new Dignity and Quality of Life Policy was developed and approved on 11/05/12. Training will be provided by staff development and nursing supervisors to all nursing staff regarding new policy. (See Nursing Attachment C)All other staff were inserviced on the importance of dignity and respect by knocking and waiting for permission to enter a residents room. (See attachment regarding training from multiple departments which includes knocking on doors) (d) Monitoring Administration, supervisors, charge nurse, and peers will monitor compliance through daily observation. Violations will be communicated to department head for tracking patterns and individuals will be addressed as appropriate for violating resident rights.	11/23/12 11/23/12

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F 241	Continued From page 17 On 10/8/12 at 11:50 AM, a surveyor was observing the tray line in the kitchen and asked E28 (dietary staff) why plastic spoons were being placed on the trays? E28 stated that they ran out of spoons. On 10/8/12 at 12:05 PM, E24 (dietary staff) delivered the second meal cart to the third floor. E24 was asked why there were disposable plastic utensils on the trays. He stated that dietary ran out of regular utensils. 16. On 10/1/12 at 11:10 AM during the resident interview, an observation was made of E16 (CNA) who knocked on R41's door, but failed to wait for the resident's permission to enter. E16 stated that she wanted to fill the resident's water pitcher and took the water pitcher and left. On 10/1/12 at 11:12 AM, E16 knocked on R41's door and again entered during the resident interview without waiting for the resident to give permission for her to enter. On 10/1/12 at 11:13 AM, in an interview, E16 confirmed that she had not waited for permission to enter R41's room. On 10/4/12 at 11 AM, E17 (CNA) entered R41's room, after seeing the surveyor she knocked after entering about 4 - 5 feet into the room and she did not wait to ask permission to enter. E17 stated that she was just cleaning up the bedside table for R41's roommate. During the conversation in the room, E17 confirmed the observation and stated "your right".	F 241		

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OMB NO. 0938-0391

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	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

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EMILY P. BISSELL HOSPITAL	3000 NEWPORT GAP PIKE WILMINGTON, DE 19808

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F 241	Continued From page 18 The facility failed to promote care for R41 in a manner and in an environment that maintained or enhanced R41's dignity. 17. Lunch observations were made in the dining room on the 2nd floor on 10/1/12. At 11:55 AM, E8 (LPN) was observed feeding 2 residents (R34 and R67) seated near each other. E8 stood over the residents while going back and forth feeding R34 and another resident at the same time. 18. At one point, another staff member took over feeding R67 and when E8 returned from another task (she left while feeding the residents several times), she squatted down in front of R34 to resume feeding her. Observation revealed that there were several vacant chairs available for E8 to use while feeding the resident. The facility failed to promote resident dignity in dining for R34 and R67 by standing over them and/or squatting in front of them while assisting them to eat and by not feeding them without leaving to complete other tasks.	F 241 Nursing 241 # 17 & 18 (a) Immediate Correction Action	Once the facility was notified of the deficient practice, corrective action was immediately taken by educating ***(E8)*** about the need to focus attention on the resident being assisted and to avoid standing over residents or squatting before residents during dining. ***(E8)*** received reminders on providing care for residents in an environment that maintained or enhanced resident's dignity.	10/12/12
		(b) Identifying other Residents having potential to be affected	All Residents have the potential to be affected by this deficiency.	
		(c) Systemic Response	A new Dignity and Quality of Life Policy was developed and approved on 11/05/12. Training will be provided by staff development and nursing supervisors to all nursing staff regarding new policy. Training will focus on resident's dining experience. Maintaining resident's dignity while feeding (use of regular silverwares for dining, instead of disposable plastic utensils); not standing over residents while feeding, and knocking on resident doors and waiting for response before entering resident rooms. ***(See Attachment B)***	12/15/12
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	(d) Monitoring	Nursing Supervisors, Infection Control nurse, Nurse managers, staff development, Care Plan Coordinator, and Charge Nurses will nonitor compliance through daily observation. The resident Dining Experience Feedback Tool will be utilized to identify any further concerns ***(See Attachment C)***	12/15/12

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F 246	Continued From page 19 Based on observation and interview, it was determined that the facility failed to ensure that two (R33 and R60) out of 39 stage 2 sampled residents had reasonable accommodation of their needs. The facility failed to ensure that R33's call bell was within reach and failed to honor R60's food preferences. Findings include: 1. On 10/1/12 at 2:05 PM, R33 was observed lying in bed on his back and his specialized touch pad call bell was lying on the floor on the left side of bed. E18 (Certified Nurse Aide-CNA) was called into the room and confirmed that R33 was capable of using call bell and that it was out of his reach. 2. R60 had diagnoses that included Multiple CVA (strokes), Mitral Valve Endocarditis (inflammation of the inner layer of the heart), hypertension, Diabetes Mellitus type 2; seizure disorder, gastro-esophageal reflux disease and high blood cholesterol level. According to R60's Minimum Data Set (MDS) assessment, dated 9/26/12, this resident's cognitive skills in daily-decision making were independent. Due to a history of CVA and paralysis, he was unable to provide for any of his needs. R60 was dependent on staff for all activities of daily living, except for eating. R60 was on a "regular diet." and was able to feed himself after set-up. On 10/2/12 at 2:56 PM, R60 was observed in his room, seated in a wheelchair eating his lunch which consisted of spaghetti and sauerkraut. R60 stated that he had ordered a hot dog, sauerkraut and French fries. Instead he was served the	F 246	#1 (a) Immediate Correction Action: Upon notification of deficient practice, corrective action was immediately taken by placing *(R) # 33* call bell within reach, on 10/01/12. *(E) # 18* received counseling regarding call bells to be within reach of residents.	10/1/2012
			(b) Identifying Other Residents having the potential to be affected: All residents have the potential to be affected by the cited deficient practice. A sweep of resident's rooms was conducted to ensure that their call bells were accessible and within reach.	
			(c) Systemic Response: Nursing staff will continue the practice of every 2 hour rounds by Certified Nursing Assistants to assure that call bells are within reach of the resident. This will be documented on the resident's flow sheet each shift. In addition, all Licensed Nursing personnel will check placement of call bells when in resident's room administering medication or performing treatments.	11/30/12
			(d) Monitoring: Nursing Supervisors, Unit Managers and Charge Nurses will perform random spot checks for the appropriate placement of resident's call bells. Any concerns will be addressed by the Nursing Supervisors and reported to the ADON / DON for corrective action.	11/30/12 and ongoing

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F 246	Continued From page 19 Based on observation and interview, it was determined that the facility failed to ensure that two (R33 and R60) out of 39 stage 2 sampled residents had reasonable accommodation of their needs. The facility failed to ensure that R33's call bell was within reach and failed to honor R60's food preferences. Findings include: 1. On 10/1/12 at 2:05 PM, R33 was observed lying in bed on his back and his specialized touch pad call bell was lying on the floor on the left side of bed. E18 (Certified Nurse Aide-CNA) was called into the room and confirmed that R33 was capable of using call bell and that it was out of his reach. 2. R60 had diagnoses that included Multiple CVA (strokes), Mitral Valve Endocarditis (inflammation of the inner layer of the heart), hypertension, Diabetes Mellitus type 2, seizure disorder, gastro-esophageal reflux disease and high blood cholesterol level. According to R60's Minimum Data Set (MDS) assessment, dated 9/26/12, this resident's cognitive skills in daily-decision making were independent. Due to a history of CVA and paralysis, he was unable to provide for any of his needs. R60 was dependent on staff for all activities of daily living, except for eating. R60 was on a "regular diet." and was able to feed himself after set-up. On 10/2/12 at 2:56 PM, R60 was observed in his room, seated in a wheelchair eating his lunch which consisted of spaghetti and sauerkraut. R60 stated that he had ordered a hot dog, sauerkraut and French fries. Instead he was served the	F 246	#2 (a) Immediate Corrective Action Review of R60 menu selection for 10/2/12 indicated two entrees were selected. Potocol states a Resident can only have one entrée. Dietician Assistant eliminated one entrée, in this case the hot dog. Sauerkraut was listed as a vegetable and remained on the menu selection. The same circumstances occurred when the hot dog was eliminated but the roll remained under bread option. In both cases resident was not consulted when the Dietation Assistant eliminated an item resident selected. (b) Identifying other residents having the potential to be affected All residents have the potential to be affected by this practice. (c) Systemic Response Training for Dietician Assistant regarding food selections and balanced meals was completed. Residents will be consulted prior to menu changes or eliminations are made to his/her menu selection. (See attached training log) (d) Monitoring Resident Council feedback, Quarterly assessments by Dietician w/Resident. Food Service Director to complete random monitoring of menu selections to ensure accuracy. Quarterly preference meeting with residents by Dietician Assistant. All preferences will be documented.	10/24/12 11/9/12 11/12/12

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F 246	Continued From page 20 spaghetti and sauerkraut. He stated that he did not bother to have it replaced. He implied that it might take a long time to get the hot dog so he ate the spaghetti, but not the sauerkraut. He stated that the other time, he requested a hot dog and French fries, he was served a bun without a hot dog. The facility failed to ensure that R60's request and food choices/preferences were honored.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that two (R4 and R38) out of 39 sampled residents, received an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, their interests and their physical, mental, and psychosocial well-being. The facility failed to provide an on-going program of activities in accordance with R4's and R38's activity assessment & care plan. Findings include: 1. R4 had diagnoses which included Schizoaffective disorder (a mental condition that causes both a loss of contact with reality and mood problems) bipolar type, dementia, manic	F 248		

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depression and blindness.

According to R4's Minimum Data Set (MDS) assessment, dated 8/13/12, her cognitive skills for daily decision-making were severely impaired. R4 had ROM (range of motion) impairment on both sides; mobility device used was a wheel chair (HTR) high back, recliner.

R4 was totally dependent on staff for all activities of daily living, and required transfers via a mechanical lift. R4 received nourishment via a feeding tube, was unable to use a call bell. This resident has a very low activity level, and was on 1:1 visits. R4 was agitated and was constantly waving her hands and moaning.

R4's undated Resident Recreation Program Review (activity evaluation), stated the following:
Reading- staff reads to her; enjoys music - (radio-99.5)
Medical conditions that impact resident's ability to participate in activities and/or adaptation needed were severe bipolar disorder with psychiatric features, type 2 diabetes, functional blindness and dementia. The "Preferred activity setting: own room and preferred time of day- morning and afternoon".

The facility established a care plan goal on "General Care Needs," last reviewed on 8/14/12. The care plan's goal was "will maintain current low level of activity through 1:1 visits from AT (activity) staff and volunteers and occasional group activities as tolerated."

The care plan's approaches included, "encourage and monitor participation in activities ...AT staff

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F 248	Continued From page 22 will visit...1:1 talk, read women's magazines, and encourage her to sing....enjoys Johnny Mathis music. AT staff will brush her hair, and rub lotion on her hands as tolerated." All staff will escort (R4) to special events as tolerated such as music, performances, holiday parties, and resident picnic. On 10/10/12 at 10:45 AM, R4 was observed lying in her recliner in the hallway. There was no one with her. Previous to that, E19 (CNA) was observed going into R4's room followed by another CNA pushing a Hoyer lift. In an interview with E19 (CNA) on 10/10/12 at 2:50 PM, he stated that he was assigned to take care of the resident (R4) for the day. He stated that he did her ADLs (bathing and personal hygiene) care and when done he took her out into the hallway in a recliner. At 1:30 PM he placed her back in bed. When asked what kind of activity was provided to the resident today, CNA replied that R4 did not have scheduled activity and he did not take her to any activity or provide any type activity. On 10/11/12 at 4:00 PM observation revealed R4's door was closed, and the curtain was pulled but no one was with her. There was no music playing even though R4's favorite Johnny Mathis CD was observed to be available. On 10/12/12 at 10:45 AM, R4 was lying in the hallway in her recliner agitated, waving her hands up and down. The surveyor touched and slightly rubbed R4's shoulder and arms and she stopped waving hands and calmed down.	F 248		

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F 248	Continued From page 23 Review of R4's documented Activity Participation/Attendance record revealed the following: - July 2012 Activity Record indicated that Radio/CD was provided 2 times and one to one visit 5 times; a total of 7 activity encouragement/participations out of 31 days. - August, 2012 Activity Program Attendance Record indicated that 1:1 programming occurred 5 times on 8/4, 8/13, 8/19, and 8/27; 8/18/12 pet therapy, independent activities such as radio, reading to resident, family visits was 0; music x 1, a total of 6 activity participation out of 31 days. - September, 2012 Activity Attendance Record indicated that 1:1 Programming/Music/art was 1x; group activity of music/sing along was 1x; 1:1 visit was 2 x and independent of TV/radio was 11 x, a total of 15 days out of 30 days. - October 1-9/12 Activity Attendance Record indicated that emotional/social visit was 1 x and independent activities of TV/radio was 7x, a total of 8 days out of 9 days. Interview with E15 (Activity Director) on 10/12/12 at 9:30 AM revealed that the activity staff members consisted of 4 aides, full time and seasonal. These aides provided the activity one-one programming, such as reading, setting up radio/TV and that can occur at any time. This finding was discussed with E15 on 10/12/12 at 9:30 AM and E1 (Hospital Director), E2 (Hospital Administrator), and E3 (Director of Nursing) on 10/12/12 at 4:00 PM. Cross refer to F279, example #3b 2. Diagnoses for R38 include being in a persistent	F 248 (a) Identifying other residents having the potential to be affected (b) Immediate Corrective Action (c) Systemic Response	Activity staff received in-servicing regarding following the care plan and documentation of resident participation in activities on the Program Attendance Record. All residents that are care planned or may be care planned for 1:1 Activity Therapy could be affected by this deficiency. All C.N.A will indicate on the C.N.A flow sheet what type of sensory stimulation was provided to all residents that are care planned for sensory stimulation. residents care planned for 1:1 Activity Therapy will receive a minimum of 30 minutes per week of activities based on their assessed interests. Program Attendance Record was revised and implemented (See attached form) Activity staff received follow up in-servicing regarding following the care plan and documentation of resident participation in activities on the Program Attendance Record.	10/22/12 12/15/12 and ongoing

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F 248	Continued From page 24 vegetative state. R38 was dependent on staff for all care and activities. Review of the Resident Recreation Program Review for R38, dated 7/17/12, listed activity preferences for listening to rock n' roll music and being around animals. It was noted that R38 received 1:1 visits. A quarterly activity note, dated 2/15/12, stated that R38 had a moderate level of activity with 1:1 visits where he was read to and his CD player was put on for him with classic rock CD's. It was noted that the resident attended music entertainment, special holiday parties and TV for stimulation. On 5/19/12, activity staff stated that R38 was up in his wheelchair daily and was escorted to activity events as silent participator for stimulation. On 8/7/12, a note was written stating that R38 continued to receive staff and pet visits and to continue to follow care plan goals and approaches. Review of R38's activity care plan, last revised on 8/14/12, listed the goal "... maintain current level of activity by tolerating 1:1 visits from staff including AT staff and volunteers. He will open his eyes when receiving visits and make eye contact when spoken to/read to." Approaches included: monitoring activity level quarterly and as needed, 1:1 visits in R38's room to play classic rock CD's, read articles from magazines, the newspaper and talk to him about current events. Also, staff will escort R38 to special events such as holiday parties, resident picnics and music performances. Under R38's hospice care plan, the approach "Encourage/assist (R38) with activities of interest. Assist... to activity of choice." Although being	F 248 (d) Monitoring	The Activity Therapist will audit 2-4 residents from each of the four (4) Activities Aides case load on a monthly oasis and will send findings to the Hospital Social Services Administrator for review. The Registered Nurse Assessment Coordinator will monitor the C.N.A. flow sheets on a monthly basis and will report finding to the DON to ensure compliance.	11/30/12 and ongoing

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around animals was listed as an activity preference on the 7/17/12 Resident Recreation Program review, it was not on R38's current activity care plan.

R38's activity program attendance from August 2012 through October 10, 2012 revealed the following:
August- 1:1 visits checked 6 out of 31 days. There were 3 notes written by activity staff-all on dates checked for 1:1 visits. On 8/2 it was noted that the residents door was closed and on 8/15 it was noted that "... he was sitting up in his chair with tv on so I sat with him for a little while."
TV/radio was checked 19 out of 31 days.
September- 1:1 visits checked 13 out of 30 days. There were 3 notes written. On 9/14, a 1:1 visit was checked as done, however, the note stated, "Saw (R38) today I faced him toward the tv so he could see it better." A note written on 9/20 stated that R38 was shown pictures from the residents picnic.
TV/radio checked 19 out of 30 days.
October 1-10: 1:1 visit checked 1 out of 10 days. The only note written, dated 10/2, stated that CNA's were in R38's room providing morning care. A 1:1 visit was documented for this date.
TV/radio checked 9 out of 10 days.

From 8/1/12 through 10/10/12, there was only documentation to support 1:1 visits in accordance with R38's care plan 4 times (includes a note written on 10/7/12 that was not checked off. Activity attendance records did not list any other activities for R38.

The facility activity schedule was reviewed from August through October 1012. The following

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F 248	Continued From page 26 preferred activities were scheduled that R38 did not attend: Room visits- 8/5, 8/25, 9/9, 9/24, 9/29, 10/1, 10/3 Music activities- 8/16 Night in Paris Dance, 9/14 chair dancing, 9/18 Music & Movement, 10/7 Piano player, 10/9 Music & Movement Resident Family Picnic- 9/15 Pet visits- none There were multiple observations of R38 from 10/5/12 to 10/12/12. Although R38 had a CD player in his room with his favorite music; no music was heard, there were few times that his TV was on, and no 1:1 room visits or pet visits were observed. R38 was not observed attending any activities. The facility failed to provide an on-going program of activities in accordance with R38's activity assessment & care plan.	F 248		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Findings include: 1. Observation on 10/1/12 at 11:45 AM with E25 (Physical Plant Superintendent) of resident room 201 revealed the following:	F 253		

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F 253	Continued From page 27 - a gap (greater than 4 inches) between the foot area of the bed frame and the mattress. The mattress was smaller than the bed frame. - a dirty pull cord in the bathroom emergency call bell system. - brown dirt on the external surface of a trash can inside the room at the entrance to the room. - a dirty/stained floor around the toilet area in the bathroom. Observation on 10/3/12 at 9:30 AM of the trash can revealed it was still dirty and the toilet area remained stained. In an interview with E25 on 10/3/12 at 9:28 AM, he stated that the toilet floor had been cleaned with new equipment that had been purchased, but the stains were not removed. Additionally, he stated that the bed was replaced. 2. Observation on 10/1/12 at 3:19 PM of room 204 revealed a dirty, stained floor around the toilet area of the bathroom. In an interview with E25 (Physical Plant Superintendent) on 10/1/12 at 3:20 PM, he revealed that he purchased new scrubbing equipment to allow them to clean around the toilet but that it had not yet been used. On 10/3/12 at 9:28 AM, E25 stated they used the new scrubbing machine to clean around the toilet area floor in resident room 204. They removed the dirt, but the stains were not removed. 3. On 10/2/12 at 9:25 AM, an observation of the back rest of R41's electric wheel chair revealed two torn outside corners. Each tear was 3 inches long by one inch wide exposing the foam fabric and plywood of the back rest. On 10/2/12 at 9:30 AM in an interview, E18 (CNA) confirmed this	#1 (a) F 253 Immediate Correction Action	Bed in 201 identified by surveyor was exchanged with a bed that accommodated the mattress eliminating the four inch gap. Maintenance given list of five beds identified to evaluate bed or foot board relocation potential or bed replacement option. Bed modified/exchanged for five beds found with a gap four inches or greater	10/2/12 10/29/12 11/2/12
		(b) Identifying other Residents having potential to be affected	All Residents have the potential to be affected b this deficiency. Assessment of every Resident bed was completed by materials management supervisor and ADON to identify other residents affected by this deficiency. Five resident beds were identified.	10/25/12
		(c) Systemic Response	Mattress extender cushions purchased to maintain in stock for future immediate correction should a gap four inches or greater is found. Future purchases of mattresses will be for mattress measuring 80". Housekeeping (who cleans beds), Nursing staff, Maintenance (who repairs beds) and Materials Management (who purchase equipment) were trained on proper size of mattress to bed frame.	
		(d) Monitoring	Housekeeping will position and report any gaps four inches or greater upon discovery. Maintenance repairing beds or exchanging will measure both to ensure adequate compatibility prior to placement. Materials management will measure both bed and mattress when placing a new mattress to a resident bed. Nursing staff to report any discrepancies monitor daily. Ground rounds monthly checklist will include monitoring of beds/mattress gaps for ongoing monitoring.	11/26/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Survey Completed date: 10/12/12

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F 253	Continued From page 27 - a gap (greater than 4 inches) between the foot area of the bed frame and the mattress. The mattress was smaller than the bed frame. - a dirty pull cord in the bathroom emergency call bell system. - brown dirt on the external surface of a trash can inside the room at the entrance to the room. - a dirty/stained floor around the toilet area in the bathroom. Observation on 10/3/12 at 9:30 AM of the trash can revealed it was still dirty and the toilet area remained stained. In an interview with E25 on 10/3/12 at 9:28 AM, he stated that the toilet floor had been cleaned with new equipment that had been purchased, but the stains were not removed. Additionally, he stated that the bed was replaced. 2. Observation on 10/1/12 at 3:19 PM of room 204 revealed a dirty, stained floor around the toilet area of the bathroom. In an interview with E25 (Physical Plant Superintendent) on 10/1/12 at 3:20 PM, he revealed that he purchased new scrubbing equipment to allow them to clean around the toilet but that it had not yet been used. On 10/3/12 at 9:28 AM, E25 stated they used the new scrubbing machine to clean around the toilet area floor in resident room 204. They removed the dirt, but the stains were not removed. 3. On 10/2/12 at 9:25 AM, an observation of the back rest of R41's electric wheel chair revealed two torn outside corners. Each tear was 3 inches long by one inch wide exposing the foam fabric and plywood of the back rest. On 10/2/12 at 9:30 AM in an interview, E18 (CNA) confirmed this	F 253 #2 (a) Immediate Correction Action	Maintenance/housekeeping completed a room by room assessment of trash cans, pull cords, and bathroom flooring in all Resident room on M2 and M3. No additional deficiencies were found outside surveyors findings in Rm 201 and Rm 204. 10/16/12 Dirty pull cord was replaced on 10/2/12. 10/2/12 Trash can was power washed and returned to Rm 201. 10/3/12 Bathroom flooring was cleaned and stained remained. Pull cords were upgraded from string to a vinyl cord. 10/4/12 Housekeeper to wipe vinyl cords daily. (See pull cord invoice) 10/4/12 (b) Identifying other Residents having potential to be affected All Residents have the potential to be affected by this deficiency. (c) Systemic Response Residential trash cans will be wiped down daily Inside and out. They will be removed bi-annually and replaced with clean can. Cans will be power washed and stored for exchange. Rooms 201 and 204 bathroom floor will receive new tiled flooring. (d) Monitoring Maintenance and housekeeping staff to be informed of new protocol. Maintenance and Housekeeping supervisors to add each item listed on rounds sheet to be completed weekly.	

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		(b) Identifying other residents having the potential be affected	Residents with upholstered wheelchairs both electric and manual could be affected by this deficiency.	
		(c) Systemic Response	The Adaptive Equipment Department will be completing preventive maintenance and repairs on all wheelchairs.	10/25/2012
		(d) Monitoring	The physical therapy department will check all upholstered wheelchairs, in use, for needed Repairs on a bi-weekly basis.	

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F 253	Continued From page 28 finding.	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the Minimum Data Set (MDS) assessment	F 278 (a) Immediate Corrective Action	*Item # 1* (R) # 40 quarterly MDS assessment dated 07/20/12 was incorrectly coded in section "N" as a (0) for anti-anxiety use. The MDS Assessment of R # 40 was accurately coded in the appropriate section ("N"), to reflect the PRN usage of anti-anxiety medication on 10/26/12. *Item # 2* (R) # 10 care plan was inaccurately coded as having a seizure disorder. Once informed about this deficient practice, R10"s care plan was revised and updated to reflect resident's current diagnosis on 10/15/12. (b) Identifying other residents having the potential to be affected All residents have the potential to be affected by the cited deficient practice. Nursing Department completed a review of all residents care plans and MDS to ensure that assessments accurately reflect resident's current status. (c) Systemic Response RNAC (Registered Nurse Assessment Coordinator) was in-service by DON (Director of Nursing) regarding coding of section "N" on the MDS 3.0, under the new guidelines. RN Unit Managers were in-service regarding MDS assessments and accurate care planning. RNAC will review the following records weekly prior to inputting data into the MDS, the medication administration record, treatment record, History and Physical, Care Plans and Nursing notes. **(See Attachment D)**	10/26/12 10/15/12 11/13/12 11//8/12

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F 278	Continued From page 29 accurately reflected the status of two (R10 and R40) out of 39 Stage 2 sampled residents. For R10, the facility incorrectly coded the resident as having a seizure disorder and for R40, the facility failed to code Section N, Medications for antianxiety use. Findings include: 1. Review of R40's Medication Administration Record (MAR) for 7/12 revealed that R40 received a prn (as needed) dose of Lorazepam 0.5 mg, an antianxiety medication, on 7/15/12 at 2 AM and on 7/20/12 at 12:05 AM for increased anxiety and agitation. The quarterly MDS assessment, dated 7/20/12, was incorrectly coded in section N, Medications as "0" for antianxiety use. On 10/8/12 at 11:37 AM in an interview, E13 (RNAC) confirmed the inaccuracy for antianxiety use in section N of the 7/20/12 MDS assessment. She stated that she only checked the nurses' notes and did not check the MAR for Lorazepam use. The facility failed to accurately code the 7/20/12 MDS to reflect R40's use of an antianxiety medication. 2. Review of R10's 3/9/12 quarterly and 6/8/12 annual MDS' coded the resident as having a seizure disorder. On 9/7/12, R10's quarterly MDS did not list her as having a seizure disorder. Review of the clinical record revealed that the only other documentation of a seizure disorder for R10 was in the care plan. On 10/12/12 during the informational meeting, E36 (Medical Director) stated that R10 does not have a seizure disorder. The facility failed to	F 278 (d) Monitoring	All residents care plans will be reviewed quarterly by RN Unit Managers and the Nursing Quality Improvement Nurse. Findings will be reported to the IDCC / NQI team for appropriate corrective action.	11/30/12 and ongoing

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F 278	Continued From page 30 accurately reflect the resident's status in her 3/9/12 and 6/8/12 MDS's.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to use the results of the assessment to develop, review and revise the comprehensive care plan and/or develop measurable objectives and timetables to meet residents' needs as identified in the comprehensive assessment for 4 (R10, R26, R38 and R40) out of 39 sampled residents. Findings include:	F 279		

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F 279	Continued From page 31 Cross refer to F278, example #2 1. Review of R10's 3/9/12 quarterly and 6/8/12 annual MDS' listed R10 as having a seizure disorder. On 6/18/12, the facility developed a care plan for "potential for injury: RT (related to) seizure disorder. R10's quarterly MDS, dated 9/7/12, did not list her as having a seizure disorder. Clinical record review lacked a diagnosis of seizure disorder for this resident. On 10/12/12 during the informational meeting, E36 (Medical Director) confirmed that R10 does not have a seizure disorder. The facility incorrectly initiated a seizure disorder care plan for R10. 2. R26 had right knee surgery on 7/12/12. R26 had PT (physical therapy) ordered pre and post-operatively. On 10/1/12, R26 had orders written by the orthopedic surgeon for PT 3 times a week and weight bearing as tolerated with a walker. Review of R26's record revealed that the only area of her care plan that mentioned PT was under alteration in comfort: pain right knee which stated, "PT 3x's/wk x 4 wks." There was no care plan for PT including measurable goals and interventions for this resident. E13 (RNAC) confirmed lack of a PT care plan in R26's chart on 10/9/12 at 2:45 PM. E13 stated that PT had their own care plan downstairs (in their department) and the care plans kept on the nursing units were "nursing" care plans. E13 further stated that the comprehensive care plans have "never" included PT.	F 279 (a) Immediate Corrective Action	***Item # 1 (R) 10*** care plan was inaccurately coded as having a seizure disorder. Once informed about this deficient practice, ***R #10"s*** care plan was revised and updated to reflect resident's current diagnosis on ***10/15/12.*** ***Item # 2 (R) 26*** Immediate corrective action was taken by updating **R # 26** care plan to reflect the need for Physical Therapy with measurable goals and interventions on **10/10/12.** ***(E13)*** Received reminders to coordinate with Physical Therapy Department in developing comprehensive care plans with measurable goals and interventions for all residents participating in Physical Therapy. ***Item # 3(a)*** Immediate corrective action was taken by updating ***R # 38*** care plan to reflect resident's current status as having a stage (4) pressure ulcer ***10/15/12.*** ***Item # 4 (R) 40*** Once informed of the incident, corrective action was immediately taken by revising resident's care plan to include current diagnosis of Anxiety Disorder. **R #40's** care plan was updated to reflect the use of antianxiety medication, with both non-pharmacological and pharmacological approaches. ***10/09/12.*** Staff received reminders regarding monitoring effectiveness of medication and documentation of interventions in resident clinical record. b) Identifying other residents having the potential to be affected All residents have the potential to be affected by this practice.	10/10/12 10/15/12 10/9/12

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F 279	Continued From page 32 Findings were discussed with E3 (Director of Nursing) on 10/9/12 at 3:30 PM. E3 confirmed that a PT care plan should be included in R26's comprehensive care plan (kept on the nursing unit) regardless of whether PT has their own care plan. E3 provided a copy of a care plan, dated 10/10/12, entitled "Impaired Physical Mobility" for R26 that included measurable goals and interventions provided by the PT department. 3a. Review of R38's clinical record revealed the development of a stage 2 (partial thickness loss of dermis) right popliteal (behind the knee) PU (pressure ulcer) on 8/2/12. The PU deteriorated to stage 4 (full thickness loss of dermis with exposed bone, muscle or tendon) and it was observed on 10/11/12. Review of R38's care plan revealed that the facility developed a care plan for "potential for impairment of skin integrity", last revised on 8/14/12. R38's skin was incorrectly noted to be "intact" at this time. The facility failed to develop a care plan for an actual PU for R38. 3b. Review of R38's activity care plan, last reviewed on 8/14/12, listed the goal, "... will maintain current levels of activity by tolerating 1:1 visits from staff and volunteers...." Interventions included: ... All staff including volunteers will visit (R38) 1:1 in his room to play CD's... and read magazine articles... and talk to him about current events... All staff will escort (R38) to special events...."	(c) F 279 Systemic Response	Unit Managers, NQI and RNAC, will be in-serviced by DON or designee regarding Comprehensive Care Planning. In-service will focus on accurate coding of diagnosis on care plan, tracking of new onset of stage ≥ 2 Pressure Ulcers to ensure that it IS care planned, and incooperating non pharmacological and pharmacological approaches into the care plan. The RNAC and Unit Managers will ensure that the care plan is updated immediately after each respective weekly IDCC Meeting. **(See Attachment E)** (d) Monitoring Nurse Managers or designee will review charts and report any order changes to the RNAC for care plan updates. The NQI Nurse or designee will audit care plan changes discussed at IDCC weekly. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met.	11/30/12 11/12/12

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F 279	Continued From page 33 The facility failed to have an activity care plan with measurable goals for 1:1 visits & other activities (i.e.- playing classic rock & roll CD's) for R38 who is in a persistent vegetative state and is dependent on staff to provide his activities. 4. The annual Minimum Data Set (MDS) assessment, dated 4/20/12, stated that R40 had active diagnoses which included Alzheimer's and non Alzheimer's dementia, anxiety and psychotic disorder. The Care Area Assessment (CAA's) summary was triggered for psychotropic drug use. Review of the Care Plans revealed that no care plan had been developed for R40's Anxiety disorder. On 10/9/12 at 10:35 AM in an interview, E13 (RNAC) confirmed that the facility failed to develop a care plan for R40's Anxiety disorder when psychoactive drug use was triggered in the 4/20/12 CAA's. The facility failed to develop a care plan that included measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs related to R40's Anxiety disorder based on the comprehensive assessment. The facility failed to develop a care plan with both non pharmacological and pharmacological approaches as well as monitoring for effectiveness.	F 279		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280		

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F 280	Continued From page 34 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise and individualize care plans for 4 (R5, R32, R38 and R47) out of 39 Stage 2 sampled residents. Findings include: 1. Review of R5's 10/12 monthly physician's order sheet (POS) included the following orders: "Use chest belt/pelvic clip while off facility," "OOB (out of bed) to w/c (wheelchair) daily as tolerated: chest belt in w/c to maintain upright position," and "Seat belt chest harness for safety." The facility developed a care plan on 3/12/12 for the problem "Potential for injury: RT (related to)	F 280		

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F 280	Continued From page 35 use of pelvic positioning belt-Velcro positioning belt in wheelchair (w/c) for posture and to improve sitting balance. Interventions included, "Velcro positioning belt in w/c for posture and to improve sitting balance...Velcro positioning belt in w/c for posture and to improve sitting balance only when out of facility...Check (resident name) every hour to determine proper placement of seatbelt..." This care plan had conflicting interventions listed. The following observations were made of R5: 10/2/12 at 7:35 AM - seated in w/c with button clip seatbelt and chest harness in place. R5 was waiting for transport out of the facility. 10/8/12 at 7:50 AM - seated in w/c in front of nurse's station with seat belt and chest harness secured. 10/8/12 at 8:40 AM, 10:05 AM, 2:40 PM, 3:40 PM - seatbelt in place. 10/9/12 at 3:05 PM - observed CNA removing chest harness after return from outside facility, had seat belt in place. 10/9/12 at 3:30 PM, 3:57 PM, and 4:25 PM - seat belt in place. On 10/9/12 at 4:30 PM, E40 (CNA) was interviewed. E40 stated that she worked with R5 regularly and that he only wears the chest harness when being transported out of the facility. Additionally, E40 stated that R5 wears the buckled seat belt at all times and that he is able to self release the seat belt. R5 was observed doing so during the interview. On 10/11/12 at 1:40 PM during an interview with E3 (Director of Nursing), he stated that the facility had worked to reduce its number of restraints in	F 280	(a) Identifying other Residents having the potential to be affected ***Item # 1 (R) # 5 chart*** was reviewed and evaluated. The physician Orders and Physical Therapy evaluation are currently consistent with the care plan. The care plan was revised and updated to accurately reflect the use of chest harness, seat belt and lateral positioning belt. ***10/30/12.***	10/30/12

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F 280	Continued From page 36 the facility back in December 2011. He stated that R5's chest harness was found to be restraining him from moving freely while in his w/c. E3 stated that the interdisciplinary team determined that R5 only needed the seat belt and a lateral positioning device while in the w/c. The chest harness was to be used only during transportation out of the facility. The facility failed to revise R5's care plan to accurately reflect use of the chest harness, seat belt and lateral positioning device. 2. The annual Minimum Data Set (MDS) assessment, dated 5/24/12, coded that R47 had a Brief Interview for Mental Status (BIMS) score of 2 which indicated a severe impairment in cognitive decision making. Active diagnoses on this same MDS included Alzheimer's Disease, other dementia, Anxiety disorder, Depression and Psychotic disorder. The Care Area Assessment (CAA's) summary triggered for psychotropic drug use and was checked as addressed in care plans. Review of the "Alt (alteration) in emotional status: anxiety and related disorders" developed on 9/1/11 and last reviewed on 9/4/12, revealed that the care plan failed to be revised to include non pharmacological approaches prior to the use of the prn (as needed) Lorazepam, an antianxiety medication. On 10/11/12 at 9:30 AM in an interview, E13 (RNAC) confirmed the findings.	F 280 (b) Identify other Residents having the Potential to be affected	***Item # 2 (R) 47*** Once informed of the incident, corrective action was immediately taken by revising resident's care plan to include non-pharmacological and pharmacological approaches. ***10/11/12.*** Staff reminded to use non pharmacological interventions first prior to using pharmacological approach. ***Item # 3 R # 38*** Immediate corrective action was taken by removing the inappropriate approaches from the care plan. ***R # 38*** hospice care plan has been revised to reflect resident's current status. ***10/15/12.*** ***Item # 4 (R) 32*** Although resident # 32 was care planned as not needing side rails, staff inadvertently had it up most of the time. Side rail assessment documented in resident's chart indicated that resident did not have medical symptoms that warranted the use of side rails. R #32 is able to get in and out of bed without restraints. The care plan was revised to reflect the use of the 1/4 grab bar side rails All residents have the potential to be affected by these deficient practices.	10/11/12 10/11/12 10/9/12

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	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

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F 280	Continued From page 37 3. Review of R38's care plan revealed that the facility failed to review and revise the hospice care plan, dated 9/17/12. R38 was comatose. Approaches that were inappropriate for R38 included allowing time to discuss fears/concerns. For nutrition, a goal was written " will have choice of diet" with approaches including staff will encourage family to provide favorite foods as able, use specialized feeding/positioning devices and record % of meal consumed- notify nurse if < 50%. Assist with meal set-up and assist as needed. Record review confirmed that R38 was unable to eat and is not fed by mouth; he received tube feedings only. Additionally, R38 was non-verbal and unable to discuss his fears/concerns. 4. R32 had diagnoses that included Renal failure, ESRD (End Stage Renal Disease), CVA (stroke) and dementia. According to R32's Minimum Data Set (MDS) assessment dated 7/31/12, this resident's cognitive skills for daily decision-making were moderately impaired: decisions poor and cues/supervision required. R32 needed extensive assistance of staff for all ADL (activities of daily living) functions except for bed mobility which she was independent. On 10/2/12, R32 was observed with raised bilateral 1/4 side rail/grab bars that measured 25 inches tall, 14 inches wide attached to her bed. On 10/08/12 R32 was observed while being provided care by E17 (CNA) in her room and in bed. The left siderail was up. R32 was turning from side to side independently as cued by E17.	F 280	(c) Systemic Changes The care plan coordinator will be in-serviced regarding developing comprehensive care plan. All residents chart will be reviewed at their quarterly IDCC meeting to ensure that a comprehensive care plan will be develop to address the need for appropriate approaches and interventions in the care plan including non pharmacological and pharmacological approaches. The RNAC and Unit Managers will ensure that the care plan is updated immediately after each respective weekly IDCC Meeting (See Attachment E) d) Monitoring Nurse Managers or designee will review charts and report any order changes to the RNAC for care plan updates. The NQI Nurse or designee will audit care plan changes discussed at IDCC weekly. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met.	12/15/12 12/15/12

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F 280	Continued From page 38 In an interview with E17 she confirmed that R32 did not use the siderails/grab bar for support, she turns herself and stands up OOB (out of bed) without using the 1/4 rail/grab bar. R32's Siderail Assessment/Questionnaire for: 1 full rail, 2 full rails, grab bars, 2-1//2 rails, 2-1/4 rails dated 7/25/12 was reviewed. The siderail assessment indicated that R32 did not demonstrate poor bed mobility or difficulty moving to a sitting position on the side of the bed; did not have difficulty with balance or poor trunk control; did not use the side rails for positioning or support; did not serve as an enabler to promote independence and no further assessment was needed to refer to OT (Occupational therapy) and therefore siderails did not appear to be indicated at this time. Interview with E46 (RN) on 10/11/12 acknowledged that R32 did not need to use a siderail as per assessment. However, during the survey period, it was observed that R32's bilateral siderails were up occasionally. R32's care plan entitled "General Care Needs" and "Potential for Injury related to Falls" dated 7/31/12 failed to be revised to reflect the use of the 1/4/grab bar siderails.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that the facility	F 281		

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F 281	Continued From page 39	F 281		

failed to ensure that services were provided to meet professional standards of quality in regards to medication administration and pressure ulcer staging for two (R38 and R39) out of 39 stage 2 sampled residents. Findings include:

Cross refer to F329, example #1
The Delaware Long-Term Care Pharmacy manual states under Drug Administration, "Nursing service shall observe the following drug administration guidelines: Drug Administration:...Drugs not administered should be initialed, circled and documented on back of MAR (Medication Administration Record)...Drug Administration Recording; Drugs administered (including drugs administered in error), adverse drug reactions, and omitted doses shall be documented in the patient's record as follows: record every dose of every drug administered in the patient's medication administration record (MAR) after administration...Indicate an omitted dose with a circle around the nurse's initials under the appropriate administration time..."

1. R39 had a physician's order, dated 8/18/12 which stated, "Verapamil 80 mg tablet take one tablet by mouth every 6 hours as needed for SBP (systolic blood pressure) > (greater than) 160." Verapamil is used for irregular heart rhythms and high blood pressure.

Review of the medication administration record (MAR) from 9/1/12 through 10/9/12 revealed that E9 (nurse) had initialed on ten occasions that Verapamil was given. On these ten occasions the documented systolic blood pressure was below the parameter specified by the physician's order to only administer the Verapamil when it was

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F 281	Continued From page 40 greater than 160. During an interview on 10/10/12 at 11:25 AM, E9 stated that the initials he signed off on those ten occasions meant that he took the blood pressure, not that he gave the Verapamil. E9 stated that had he given the Verapamil, he would have noted it on the back of the MAR since it was a prn (as needed) order. E9 failed to follow the facility's pharmacy policy and current standards of practice in medication administration. On 10/10/12 at 3:00 PM during an interview with E3 (Director of Nursing, findings were reviewed. E3 acknowledged that standards of practice regarding medication administration were not followed and that the Verapamil was signed off as having been given. 2. The National Pressure Ulcer Advisory Panel (NPUAP) Staging System, revised in 2007, stated, "... Stage 2- Partial thickness loss of dermis (middle layer of skin) presenting as a shallow open ulcer with a red pink wound bed, without slough (stringy, necrotic-dead tissue)... Presents as a shiny or dry shallow ulcer without slough or bruising... Stage 3- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss... Stage 4- Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (thick, leathery black crust; nonviable tissue) may be present on some parts of the wound bed...." Review of R38's Weekly Wound Tracking sheets revealed that R38 was identified on 8/2/12 as	(a) Immediate Corrective Action (b) Identifying Other Residents Having the Potential To be Affected	***Item # 1*** Once the facility was notified about the discrepancies in the infection control data, Immediate corrective action was taken by correcting the weekly line listing and the monthly infections analysis reports for January and June of 2012. ***(E # 14)*** received reminders in regards to keeping accurate documentation including trends of infections, patterns, outbreaks, and clusters. ***Item # 2 R # 38*** Once it was brought to the attention of the facility, the infection control nurse took immediate action to correct the weekly wound assessment sheet to reflect resident's current status as regards staging of his wound. All related records were updated to reflect same. ***10/15/12.*** Current NPUAP Staging Guidelines were reviewed with ***E14*** on ***11/08/12.*** Although there were no negative outcome in the case of R#38, all residents have the potential to be affected by these deficient practices.	11/10/12 10/15/12

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F 281	Continued From page 41 having a stage 2 right popliteal (behind knee) pressure ulcer (PU). E14 (Infection Control/Wound Care Nurse) staged R38's PU as stage 2 although she noted 50% slough on 8/10/12 and 25% slough on 8/14/12. R38's PU was observed on 10/11/12 and was stage 4 with exposed tendon as identified on 8/29/12. E14 (Infection Control/Wound Care Nurse) was interviewed on 10/12/12. When asked why she staged the PU as stage 2 on 8/10/12 and 8/14/12 when there was slough present (stage 3), E14 stated because there was 50% or less slough. After reviewing the NPUAP Staging System as above (used by facility and kept with wound documentation) and R38's August 2012 Weekly Wound Tracking sheet she completed, E14 confirmed that she did not stage the PU on these dates according to the NPUAP's guidelines. Although there was no outcome for R38, potential exists for other residents in which incorrect wound staging is done and subsequent incorrect treatment is selected.	F 281	(c) Systemic Response Infection Control Nurse or designee will review weekly Wound Tracking record for discrepancies. Beginning 11/13/12 through 11/30/12, staff educators will conduct refresher in-service on medication administration with emphasis on new medication administration guidelines. Training will focus on documentation on the MAR (medication administration record), and current practice in medication administration. Nurse Managers or designee will review charts and report any order changes to the RNAC for care plan updates. The NQI Nurse or designee will audit care plan changes discussed at IDCC weekly. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met. All new hires will receive training and competency on medication administration prior to completion or orientation. The Nursing QI team, Unit Managers, and Nursing Supervisors will continue to monitor medication administration procedures. The Medication Administration Observation Audit Tool will be used to document observations ***(see Attachment F)***	11/30/12
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.		Nurse Managers or designee will review charts and report any order changes to the RNAC for care plan updates. The NQI Nurse or designee will audit care plan changes discussed at IDCC weekly. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met. (d) Monitoring Nursing Supervisors will monitor the weekly Wound Tracking Record to ensure compliance. Audit results of medication observation will be reviewed by the Nursing Quality Improvement team at their monthly meetings. Summary of corrective actions will be forwarded to the DON / ADON to determine if further intervention is necessary.	11/30/12 And Ongoing

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F 309	Continued From page 42 This REQUIREMENT is not met as evidenced by: The facility failed to ensure that three (3) residents (R32, R63 and R69) out of 39 sampled, received the necessary care and services to attain or maintain their highest practicable, physical and mental well being in accordance with the residents' comprehensive assessments and plans of care. R32 was administered 2 mg of Ativan (a high potency drug that has effects that included sedative/hypnotic, muscle relaxant, short term treatment of anxiety and sedation of aggressive patients) by mouth at 12:30 AM instead of 0.5 mg as per physician's order. R32 experienced increased lethargy but was arousable, following the administration of the medication. The facility failed to monitor blood pressures as ordered for R63. The facility also failed to perform safety checks on R69 every 15 minutes and failed to administer two medications to R69 as ordered. Findings include: 1A. Review of R69's Annual History and Physical, dated 5/23/11 revealed that R69 was admitted to the facility on 5/23/05. R69's Annual History and Physical, dated 11/10/11, revealed a past medical history of Neuroacanthrocytosis (neurodegenerative, neurologic movement disorder), Celiac disease (auto immune disease of the small intestine), seizure disorder and depression. R69's POS (Physician's Order Sheet), dated 2/16/12, included the order, "Q (every) 15 minute safety checks all shifts." Review of R69's care plan entitled, "General Care Needs... dated 3/10/10 included the goal of "...will	(a) Immediate Corrective Action F 309	***Item # 1A (R) # 69*** Once the facility was notified of the incident, corrective actions were immediately taken to rightify the deficient practice by eliminating the use of the form. Unfortunately, the safety check log had a typographical error. The form had the titled as 15 minutes safety checks, however it had 30 minutes time intervals instead of 15 minutes. Although the 15 minutes safety checks rounds were completed, they were documented wrongly. The 9:30 to 10:30 AM rounds was not documented on the safety check log. ***Item # 1 (B) R # 69*** Resident # 69 was not negatively impacted by the deficient practice cited. However, upon notification of incident, corrective action was immediately taken by initiating a medication error review and the facility medication administration policy on 10/10/12 ***(See*** **Attachment G)** A one on one focus training with ***E7*** regarding administering medication an hour before and an hour after scheduled dose was completed by DON on 11/09/12 ***(See*** **Attachment H)** ***Item # 2 R # 63*** Once the facility was informed regarding the deficient practice, corrective action was taken by initiating a new MAR (Medication Administration Record), to accurately reflect the physician order for a daily blood pressure rather than weekly. Staff received reminders about the need of transcribing physician orders accurately on the MAR. ***Item # 3 R # 32*** was not negatively impacted. Corrective actions taken included the following: 1) A medication corrective action plan initiated on 09/10/12. 2) ***E # 41*** was restricted from	10/3/12 11/9/12 10/3/12

b)

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F 309	Continued From page 43 tolerate getting OOB daily" and approaches included "...Q 15 minute face check on all shifts" (last revised on 1/10/12). Review of the March 2012, "Q 15 minutes Face Check Flow Sheet" failed to provide evidence that face/safety checks were performed every 15 minutes as ordered on 3/1/12. The flow sheet provided evidence of 30 minute face checks and not every 15 minutes. There was no evidence of face checks from 9:30 AM to 10:30 AM. During an interview on 10/3/12 at 1 PM, E3 (Director of Nursing) confirmed that R69 was on face checks every 15 minutes related to his noncompliance with safety issues and falls. He stated that R69 would try to be independent with his care but would have falls. E3 stated that R69 had "improved strength, ... but wanted to be more independent... he was young..." E3 acknowledged that the facility failed to follow the physician's order and plan of care when they failed to do face/safety checks every 15 minutes. During an interview on 10/9/12 at 12:15 PM, E20 (CNA) confirmed she documented 30 minute checks but believed she actually did face checks every 15 minutes. When asked how she documented it, she looked at the flow sheet and became confused. E20 stated that "...maybe it was changed to 30 minute checks..." but could not explain how the 15 minute face/safety check documentation was done. E20 stated that when she "signed the flow sheet - that's when the check was done... " (which according to documentation was every 30 minutes and not every 15 minutes) despite the title of the flow sheet. E20 stated that at 10 AM she was giving	F 309	administering medication pending successful completion of a refresher in-service on medication administration with staff development. 3) One on one training by DON and Nursing Supervisor regarding standard of practice (five rights), on medication administration and nursing documentation 10/12/12. ***(See* Attachment H)**	10/12/12
		(b) Identify other Residents having the Potential to be affected	All residents have the potential to be affected by these deficient practices.	
		(c) Systemic Changes	Beginning 11/13/12 through 11/30/12, staff educators will conduct refresher in-service on medication administration with emphasis on new medication administration guidelines Training will also focus on documentation on the MAR (medication administration record), and current practice in medication administration. All new hires will receive training and competency on medication administration prior to completion or orientation. The Nursing QI team, Unit Managers, and Nursing Supervisors or designee will continue to monitor medication administration procedures. The Medication Administration Observation Audit Tool will be used to document observations ***(See* Attachment I)**. Nurse Managers or designee will review charts and report any order changes to the RNAC for care plan updates. The NQI Nurse or designee will audit care plan changes discussed at IDCC weekly. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met.	12/15/12

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F 309	Continued From page 44 another resident a shower. She stated that since the nurse (E7) knew that she was giving someone a shower, she believed that either E7 would do the 15 minute face/safety check or else assign it to another CNA. During an interview on 10/9/12 at 12:26 PM. E21 (CNA) reviewed the "Q 15 minute Face Check Flow Sheet" with the surveyor. E21 stated that those "were half hour checks". E21 stated that there is another sheet used for 15 minute face/safety checks. E21 provided the surveyor with a blank copy of a 15 minute and a 30 minute face check sheet. E21 confirmed that review of her documentation on 3/1/12 for R69 was for 30 minutes. E21 stated that everyone is responsible for checks... staff are told during report who is on face checks... and nursing also checks on the residents. R69 was not part of her assignment but she knew the resident was on safety checks and since his CNA wasn't around, she did the face check at 9 and 9:30 AM. During an interview on 10/9/12 at 1:40 PM, E2 (Hospital Administrator) stated that the "Q 15 minute Face Check Flow Sheet" was an unofficial document that had incorrectly formatted the documentation for 30 minutes instead of 15 minutes. E2 stated that the form had been eliminated after it was discovered to be incorrect. E2 confirmed the findings. 1B. R69's POS (Physician's Order Sheet), dated 2/16/12, included orders for Clonazepam 1mg (milligrams) 1 tablet po (by mouth) TID (three times a day) timed for 9 AM, 4:30 PM and 9 PM and Chlorpromazine 10mg 1 tablet once daily at 9 AM.	F 309 (d) Monitoring	Audit results will be reviewed by the Nursing Quality Improvement team at their monthly meetings. Summary of corrective actions will be forwarded to DON and QA to determine if further intervention is necessary.	12/15/12

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F 309	Continued From page 45 Review of the 3/2012 MAR (Medication Administration Record) failed to have evidence that R69 received Chlorpromazine 10 mg or Clonazepam on 3/1/12 at 9 AM. During an interview on 10/9/12 at 2:20 PM, E3 (Director Of Nursing) acknowledged that R69's Chlorpromazine and Clonazepam medications were not administered as per the physician's order and the facility's policy allows the nurse one hour before to one hour after the administration time to be given and still be considered as administered on time. E3 agreed either the nurse could have circled her initials to indicate that the Clorpromazine and Clonazepam were not administered at 9 AM and/or obtained further orders from the physician to be given later when R69 awoke. E3 acknowledged that the nurse should have followed up. During an interview on 10/10/12 at 11:30 AM, E7 (nurse) confirmed that she failed to administer Clorpromazine and Clonazepam to R69 as ordered on 3/1/12. 2. R63 was admitted to the facility on 11/10/10 with diagnoses that included insulin dependent diabetes, hypertension, congestive heart failure, and chronic renal failure with dialysis services three times a week.. Review of R63's POS (Physician Order Sheets), dated 8/17/12 and 9/14/12 included a physician's order to do "Daily BP (blood pressure). OK to use Lt (left arm for BP..." R63's care plan, dated 11/10/12 and entitled,	F 309		

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F 309	Continued From page 46 "Alteration in circulation-vascular: Hypertension" included the approach/intervention to "Check (name of R63) BP per MD (physician) order and monitor for effectiveness of medications..." Review of R63's 9/2012 and 10/2012 MARs (Medication Administration Records) revealed that despite the physician orders for daily BPs, the facility was only doing weekly BPs. During an interview on 10/11/12 at 3:50 PM, E4 (nurse/unit manager) and E10 (nurse) both confirmed that R63's POS had an order for daily BPs and 9/2012 MAR stated Daily BP, but someone only blocked off boxes for weekly BPs and therefore, only weekly BPs were being done. They confirmed that the 10/2012 MAR incorrectly stated weekly BPs. The facility failed to follow the R63's physician's order for daily BPs. 3. R32 was admitted with diagnoses of renal failure, ESRD (End Stage Renal Disease), glaucoma, Hypertension, Diabetes Mellitus, CVA (stroke) and dementia. According to R32's Minimum Data Set (MDS) assessment, dated 7/31/12, her cognitive skills for daily decision-making were, "moderately impaired-decisions poor; cues/supervision required". R32 was dependent on staff for extensive assistance with her activities of daily living (ADLs) and received anti-anxiety and anti-depressant medications. The facility developed a care plan, dated 4/25/12 entitled, "Alteration in Emotional Status: Anxiety and related disorder". The approaches included, "Administer meds (medication) as ordered".	F 309		

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F 309	Continued From page 47 R32's physician prescribed and initiated the antipsychotic medications Lorazepam on 01/24/12 through current as follows: Lorazepam (Ativan) 0.5 mg take 1 tab PO q 8 hrs except 0830 (8:30 AM) dose on dialysis days. R32 was scheduled for dialysis three times a week on Mondays, Wednesdays and Fridays Lorazepam (Ativan) 2 mg tab.1 tab po at 0830 on dialysis days (three times a week). R32 was incorrectly administered 2 mg of Ativan (a high potency drug that has effects that included sedative/hypnotic, muscle relaxant, short term treatment of anxiety and sedation of aggressive patients) by mouth on 9/9/12 at 12:30 AM instead of 0.5 mg as per the physician's order. R32 experienced increased lethargy but resident was arousable, following the administration of the medication. A nurse's note dated 9/9/12 (Sunday) stated, "Message left for grandson to inform him that wrong dose of Ativan was given at 0030 (12:30 AM). Resident received 2 mg instead of 0.5 mg. Review of the Incident Report Form dated 9/10/12 (Monday) stated, "Observed 2 mg Ativan signed out for 0030 (12:30 AM).dose 0.5 mg. Ativan 2 mg is (sic) ordered to 0830 on dialysis days." A nurse's note dated 9/9/12 -1355 stated that R32 experienced increased lethargy as a result although resident was arousable and the physician was made aware. The routine Ativan 0.5 mg was held. According to the facility's "Medication Error Corrective Action Plan," E41 (LPN) who committed the error, wrote a	F 309		

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F 309	Continued From page 48 statement that indicated that "the orders were close together and I accidentally selected 2 mg instead of 0.5 mg". "In her haste, she signed out and administered a 2.0 mg by mouth of Ativan as opposed to a 0.5 mg. E41 failed to administer R32's medication as prescribed.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that a resident who was unable to carry out activities of daily living received the necessary services to maintain grooming/personal hygiene for two (R41 and R38) out of 39 Stage 2 sampled residents. R41 had repeated observations of dirty fingernails. R38 had long toenails & fingernails. Findings include: 1. Review of the annual Minimum Data Set (MDS) assessment, dated 7/24/12, revealed that R41 had a BIMS (Brief Interview for Mental Status) score of 13, indicating he was alert and oriented. R41's functional status in the annual MDS was coded as dependent with assist of 1 person for personal hygiene and bathing.	F 312		

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F 312	Continued From page 49 The care plan entitled, "General Care Needs" developed on 7/30/09 and last reviewed on 7/24/12 had goal that the resident will be clean, neat and dressed appropriately. Approaches included, "Resident profile: Assist with ADL's (activities of daily living) - 1 staff member...7-3 shift bath/shower days - Wednesday and Saturday; ... Nail Care: Check fingernails during bath days, Cut or trim or file nails on bath days and prn (as needed)..." On 10/1/12 at 11:20AM, observation of R41 revealed dirt under three of the resident's fingernails on the left hand and one on the right. On 10/1/12 at 3:05 PM a second observation was made with E11 (RN), who confirmed that R41 had dirty fingernails. Review of the 10/12 CNA Assignment Record, revealed that R41 was showered on 10/3/12. On 10/4/12 at 11:03 AM, observation of R41's fingernails revealed that the resident still had dirty nails on the left hand. At that time, the resident was asked if the staff cleaned his nails during his shower yesterday and he stated, "no". On 10/4/12 at 2:44 PM in an interview, E22 (CNA) stated that she was assigned to R41 today. E22 stated that when showered, R41 was bathed head to toe, shaved, and if his nails need to be done they are done at that time. On 10/4/12 at approximately 2:48 PM, E22 went into the resident's room with the surveyor and confirmed that the resident's 1st 3 fingers on the left hand were "dirty". E22 stated that she would clean his fingernails.	F 312		
		(a) Immediate Corrective Action	***Item # 1(R) 41*** Once the facility was notified of the deficient practice, corrective action was immediately taken by educating ***(E 11)*** about the need to perform nail care on scheduled bath days and as needed. Staff received reminders on providing care for residents in an environment that will maintained and enhanced their dignity.	10/5/12
			Item # 2 R # 38 Upon notification of incident, the RN in charge immediately trimmed ***(R # 38)*** fingernails and requested a podiatrist consult. Resident # 38 was seen by the podiatrist on 11/08/12. ***(See Attachment J)***	11/8/12
		(b) Identifying other residents having the potential to be affected	All residents have the potential to be affected by these deficient practices.	
		(c) Systemic Response	A new nursing policy on "Dignity and Quality of Life" was developed and approved on 11/05/12. Training will be provided by Staff Development, and Nursing Supervisors to all nursing staff regarding new policy. Training will cover grooming / personal hygiene related to nail and toe care. **(See Attachment B)**	12/15/12

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F 312	Continued From page 50 On 10/5/12 at 12:28 PM an observation of R41in the dining room after lunch revealed that his fingernails were clean and trimmed. The facility failed to ensure that R41, who was unable to carry out activities of daily living, received the necessary services to maintain grooming/personal hygiene related to nail care. 2. On 10/1/12 and 10/11/12, R38 was observed with long fingernails and long, thick toenails. Diagnoses for R38 include persistent vegetative state, so he was dependent on staff for all care. Review of R38's general care needs care plan, last revised 8/14/12, included the interventions "... Nail care: Check fingernails during bath days (Mondays and Thursdays). Cut, trim or file nails on bath days and PRN (as needed). Review of podiatry records revealed that R38's toenails were trimmed on 5/17/12 and on 7/19/12. The facility failed to have R38's toenails trimmed for nearly 3 months. On 10/11/12, E6 (RN) confirmed findings. E6 stated that the facility does not specifically document fingernail cutting. E6 also stated that a podiatrist comes to the facility every 2 weeks and he would place R38 on the list to be seen.	F 312 (d) Monitoring	Nursing Supervisors, Infection Control Nurse, Nurse managers, and Charge Nurses will monitor compliance through daily observation. The weekly head to toe skin assessment form will be utilized to identify any further concerns. Any concerns will be reported to the ADON / DON for corrective action.	12/15/12 And Ongoing
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		

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F 329	Continued From page 51 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for six (R10, R14, R39, R40, R47, and R63) out of 39 stage 2 sampled residents, the facility failed to ensure that the resident's drug regimen was adequately monitored or that there was an indication for use. Findings include: 1. R39 had a physician's order, dated 8/18/12 to receive Verapamil (used to treat irregular heart rhythms and high blood pressure) 80 mg every 6 hours as needed for a systolic blood pressure (SBP) greater than 160. Review of the medication administration record (MAR) from 9/1/12 through 10/9/12 revealed that	F 329	(a) Identifying other residents having the potential to be affected ***Item # 1 (R) # 39 , Item # 2 (R) # 10*** Once the facility was notified of the incident, corrective were immediately taken to rectify the deficient practice. One on one in-service was conducted by DON, regarding medication administration standard of practice related to documentation on the MAR (medication administration record) when medication is not administered (See Attachment K). ***Item # 3 (A & B) R # 63*** Once the facility was notified of the deficient practice, corrective action was taken by educating staff regarding the importance of pain assessment and the need to monitor resident when medication is administered. In-service was conducted by DON, regarding pain assessment and monitoring of resident after medication administration on 11/09/12. *(See* Attachment K ***Item # 4 (A & B) R # 14*** Once the facility was notified of the incident, corrective action was immediately taken to rectify the deficient practice. One on one in-service was conducted by DON, regarding medication administration, standard of practice related to documentation on the MAR (medication administration record) when medication is not administered. *(See* Attachment K Item # 4 (B) *R # 14 was* not negatively impacted by the deficient practice cited. Upon notification of incident, corrective action was immediately taken by obtaining psychiatrist consultation and initiating GDR for the use of the antipsychotic medication on 11/07/12.	11/9/12 11/9/12 11/7/12

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F 329	Continued From page 52 on nineteen (19) occasions the Verapamil was signed off as being given when the documented systolic blood pressure was below the parameter specified by the physician's order (to be given when SBP greater than 160). The facility failed to ensure that there was an indication for use of the Verapamil on these 19 occasions. On 10/10/12 at 3:00 PM during an interview with E3 (Director of Nursing, findings were reviewed. E3 acknowledged that the Verapamil was signed off as having been given when it should have been held. 2. R10 had a physician's order for Verapamil (antihypertensive) 80 mg 2 hours after regularly scheduled BP medication if systolic BP (top number) > 150 or diastolic BP (bottom number) > 90, dated 8/27/12. Review of R10's medication administration records for September 2012 and October 1-12, 2012 revealed that Verapamil was given when out of the ordered parameters 12 times (9/1, 9/2, 9/7, 9/12, 9/14, 9/16, 9/25 twice, 9/28, 9/29, 9/30 and 10/9). It was also incorrectly held 2 times when it should have been given (9/5 and 9/18 when diastolic BP > 90). Findings were confirmed with E3 (Director of Nursing) on 10/12/12. 3a. R63 had a physician's order, dated 8/17/12 and 9/14/12 to receive Oxycodone APAP (Percocet) 5/325 mg (milligrams) 2 tablets every	F 329 (a) Identifying other residents having the potential to be affected	***Item # 1 (R) # 39 , Item # 2 (R) # 10*** Once the facility was notified of the incident, corrective were immediately taken to rectify the deficient practice. One on one in-service was conducted by DON, regarding medication administration standard of practice related to documentation on the MAR (medication administration record) when medication is not administered **(See Attachment N).** ***Item # 3 (A & B) R # 63*** Once the facility was notified of the deficient practice, corrective action was taken by educating staff regarding the importance of pain assessment and the need to monitor resident when medication is administered. In-service was conducted by DON, regarding pain assessment and monitoring of resident after medication administration on 11/09/12. ***(See Attachment O)*** ***Item # 4 (A & B) R # 14*** Once the facility was notified of the incident, corrective action was immediately taken to rectify the deficient practice. One on one in-service was conducted by DON, regarding medication administration, standard of practice related to documentation on the MAR (medication administration record) when medication is not administered. ***(See Attachment)*** **Item # 4 (B)** *R # 14 was* not negatively impacted by the deficient practice cited. Upon notification of incident, corrective action was immediately taken by obtaining psychiatrist consultation and initiating GDR for the use of the antipsychotic medication on 11/07/12.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 329	Continued From page 53 4 hours as needed for pain. Review of the 9/12 medication administration record (MAR) revealed that on four (4) occasions (9/10 at 9:30 AM, 9/12 at 5:30 AM, 9:15 AM and 1:30 PM), Percocet was administered for complaints of groin pain. Review of the 10/12 MAR from 10/1/12 through 10/11/12 revealed that on four (4) occasions (10/1 at 10 PM, 10/3 at 8:50 PM, 10/4 at 8:30 PM, and 10/8 at 10:10 PM), Percocet was administered for complaints of back pain. Although the facility assessed R63's pain level prior to administration of the Percocet by utilizing a pain scale of 1-10, they failed to consistently re-assess the pain level post medication. The facility failed to utilize the numeric pain scale on the eight occasions listed above to monitor the effectiveness of the Percocet. During an interview on 10/12/12 at 10:15 AM, E12 (nurse supervisor) confirmed the findings and stated there was a lack of monitoring. 3b. R63 had a physician's order, dated 8/17/12 to receive Promethazine 25 mg to be given every 8 hours as needed for nausea and vomiting. Review of the MAR revealed that on 9/13/12 at 10:57 PM, Promethazine was administered for complaints of nausea. The back of the MAR and a nurse's note, dated 9/13/12 at 11 PM, documented the results as "pending". Record review lacked evidence that the facility monitored the effectiveness of the Promethazine.	F 329	Cross reference from F 281 (a) Identifying other residents having the potential to be affected ***Item # 1 (R) # 39 Resident # 39*** was ordered to take one Verapamil 80 mg tablet every 6 hours as needed for SBP > 160. Unfortunately, staff did not sign and circled initials indicating that the medication was not administered. Once informed about the deficient practice, ***Nurse E #9*** was temporarily removed from the medication cart to participate in a 1 on 1 refresher in-service on current standards of practice for documentation regarding administering medications with parameters *(See* Attachment M. ***Item # 3 R # 38*** Once it was brought to the attention of the facility, the infection control nurse took immediate action to correct the weekly wound assessment sheet to reflect resident's current status as regards staging of his wound. All related records were updated to reflect same. ***10/15/12.*** Current NPUAP Staging Guidelines were reviewed with ***E14*** on ***11/08/12.*** (b) Identify other Residents having the Potential to be affected Although there was no negative outcome in the case of R#38, all residents have the potential to be affected by these deficient practices. (c) Systemic Changes Beginning 11/13/12 through 11/30/12, staff educators will conduct refresher in-service on medication administration with emphasis on new medication administration guidelines Training will also focus on documentation on the MAR (medication administration record), and current practice in medication administration.	11/9/12 11/9/12 12/15/12

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F 329	Continued From page 54 During an interview on 10/12/12 at 10:15 AM, findings were confirmed by E4 (nurse/unit manager). 4a. The physician's history and physical, dated 10/25/11, revealed that R14 had diagnoses including hypertension, Organic Brain Syndrome, Multi infarct dementia with Psychotic features and chronic Anxiety Syndrome. The psychiatric consult, dated 2/20/11, noted R14 had major depression with psychotic features. Review of the 8/12 and 9/12 Physician's Order Sheet, revealed that R14 had an order to receive the antihypertensive medication, Lisinopril 20 mg daily in the morning, hold if SBP (systolic blood pressure) is less than 120. Review of the 8/12 Medication Administration Record (MAR) revealed that Lisinopril was signed off as being given on 8/19/12 without any blood pressure (BP) taken. Additionally, it was signed off as given on 8/31/12 with a BP of 116/69 when the SBP was less than 120. The medication was not circled to indicate that it was not given and also was not noted as held or not given on the back of the MAR. Review of the 9/12 MAR revealed that Lisinopril was signed off as given outside of parameter on 9/5/12 with a recorded of BP 111/72 and on 9/12/12 with a recorded BP of 115/71. The medication was not circled to indicate that it was not given and also was not noted as held or not given on the back of the MAR. Review of the nurses notes for those dates revealed that there was no documentation that	F 329	All new hires will receive training and competency on medication administration prior to completion or orientation. The Nursing QI team, Unit Managers, and Nursing Supervisors or designee will continue to monitor medication administration procedures. The Medication Administration Observation Audit Tool will be used to document observations *(see* Attachment F Nurse Managers or designee will review charts and report any order changes to the RNAC for care plan updates. The NQI Nurse or designee will audit care plan changes discussed at IDCC weekly. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met. (d) Monitoring Audit results will be reviewed by the Nursing Quality Improvement team at their monthly meetings. Summary of corrective actions will be forwarded to DON and QA to determine if further intervention is necessary.	12/15/12 12/15/12 12/15/12

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F 329	Continued From page 55 Lisinopril was held. The facility failed to ensure that there was monitoring for use of the antihypertensive medication, Lisinopril. On 10/12/12 at 10:25 AM, findings were confirmed by E12 (RN Supervisor). 4b. On 2/15/11, E36 (Physician) wrote the order, "Consult Dr. (name) E42 (Psychiatrist) to re eval (reevaluate) psych tx. (psychiatric treatment)." On 2/20/11, E42 saw R14 and recommended,"Titrate Seroquel < or = (less than or equal to 300 (mg)/day (pt [patient]did well c [with] 200 [mg] /day)...Imp. (Impression) major depression c psychotic features in remission. Rec. (recommendations) Cont (continue) current tx (treatment) If pt stable x (for) 12 mos, then consider cautious Seroquel taper by 25 mg/month." Review of E43's (Nurse Practitioner) initial note, dated 7/30/12 stated, "Anticipatory Plan of Care...**GDR (gradual dose reduction) psychotropic". A second monthly note completed by E43, dated 8/24/12 stated, "Anticipatory Plan of Care...**GDR (gradual dose reduction) psychotropics (Dr (name-E36) aware of suggestion via email from last visit), Psych consult?". On 10/12/12 at 11 AM, the Physician's Order Sheets were reviewed from 2/11 through 8/12 by E3 (DON) and the surveyor. This review revealed that R14 had physician's orders to receive the same dose of the antipsychotic medication, Seroquel 150 mg twice a day. In an interview at that time, E3 (DON) stated that he spoke with	F 329		

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F 329	Continued From page 56 E36, who stated the Psychiatrist's consult was only a recommendation and that E36 thought there may have been a dose reduction that did not go well in the past. However, E3 stated that he was unable to find any documentation of any GDR. The facility failed to ensure that a GDR was done for the use of the antipsychotic medication, Seroquel. 5. R40 had diagnoses including dementia, depression and anxiety. Review of the 7/12 Physician's Order Sheet revealed that R40 had an order to receive Lorazepam 0.5 mg every 8 hours prn (as needed) for agitation/anxiety. The 7/12 MAR (medication administration record) noted that R40 had Lorazepam 0.5 mg on 7/15/12 at 11 PM for increased anxiety, agitation, banging on medication room door with pending effect. The NN on 7/15/12 at 11:12 PM also noted result pending. No outcome was recorded. The 7/12 MAR noted that R40 had Lorazepam 0.5 mg on 7/23/12 at 1:30 AM for increased anxiety, agitation with no effect. On 7/23/12 at 3:45 AM the NN stated, "Resident had increased agitation on call bell asking for juice. Received prn Latvian @0130 (1:30 AM) with no effect. Resident in room @ this time awake." There was no documented evidence that R40 received the juice she requested or that any other non pharmacological approaches were attempted prior to the administration of the prn Lorazepam.	F 329		

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F 329	Continued From page 57 On 10/9/12 at 10:35 AM in an interview E13 (RNAC) confirmed the findings. The facility failed to initiate non pharmacological approaches prior to use of Lorazepam and failed to monitor the effectiveness of prn Lorazepam. On 10/9/12 at 3:20 PM E3 (DON) also confirmed the findings. 6. R47 had diagnoses including Alzheimer's Disease, Anxiety disorder, Depression and Psychotic disorder. Review of the 8/12 and 9/12 Physician Order Sheets revealed that R47 had an order to receive Lorazepam 0.5 mg every 8 hours prn (as needed) for agitation. Review of the MAR (medication administration record) revealed that R47 received prn Lorazepam on 8/11/12 at 1:20 AM for agitation without any result noted on the MAR, nor was there a nurse's note (NN) for the 11-7 shift on 8/11/12. The MAR revealed that R47 received prn Lorazepam 0.5 mg at 12:40 PM on 9/1/12 for increased agitation with no result noted. There was no NN for 9/1/12. Additionally, on 9/13/12 at 1:05 AM, R47 received prn Lorazepam 0.5 mg. The NN on 9/13/12 at 1:05 AM stated, "Resident appeared agitated, medicated c (with) Ativan 0.5 mg po at 0105 c + effect, resident is,calm, resting on the bed at this time." There were no non pharmacological approaches documented nor underlying cause noted in NN prior to administration of prn Lorazepam.	F 329		

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F 329	Continued From page 58 On 10/11/12 at 9:30 AM in an interview, E13 (RNAC) confirmed the findings. The facility failed to initiate non pharmacological approaches prior to use of Lorazepam and failed to monitor the effectiveness of prn Lorazepam	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that two (R63 and R69) out of 39 stage 2 sampled residents were free of significant medication errors. The facility failed to administer scheduled doses of Lantus insulin for R63 and Phenytoin (Dilantin) for R69. Findings include: 1. R63 was admitted to the facility on 11/10/10 with diagnoses that included juvenile onset, insulin dependent diabetes mellitus, diabetic gastroparesis and diabetic retinopathy. R63 had a physician's order, dated 9/14/12 for 15 units of Lantus insulin (long-acting insulin) 100 units/ml subcutaneously before breakfast at 5 AM and at 10 PM with the parameter to hold if BS (blood sugar) was less than 110. R63 also had a physician's order, dated 9/14/12 for accuchecks (fingerstick testing of blood sugar levels) at 5 AM, 11:30 AM, 4 PM and 10 PM, and to call the physician if the BS was greater than 450 or less than 60.	F 333		

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F 333	Continued From page 59 R63's BS flow sheet revealed a reading of 541 on 9/30/12 at 10 PM. A physician's order, dated 9/30/12 stated, "Check BS before eating. Give 12 units of Humalog for BS of 541 x (times) 1 dose now." A nurse's note, dated 9/30/12 stated, "...BS checked 541. Received order administer 12 units of Humulog (sic). Monitor if he eats, take BS before he eats. No s/s (signs/symptoms) of hypo/hyperglycemia..." Review of the MAR (Medication Administration Record) revealed that R63 received a one time dose of Humalog 12 units at 10:15 PM on 9/30/12. However, the same MAR lacked evidence that R63 received his scheduled dose of Lantus 15 units at 10 PM on 9/30/12. During an interview on 10/12/12 at 11:35 AM, E4 (nurse/unit manager) confirmed the findings after reviewing R63's record. E4 acknowledged that R63 should have received both the Humalog and the Lantus insulin. 2. R69 was admitted to the facility on 5/23/05 and had diagnoses that included Neuroacanthrocytosis (neurodegenerative, neurologic movement disorder), Celiac disease, seizure disorder and depression. R69 had a physician's order, dated 2/16/12 to receive Phenytoin Sodium (anticonvulsant) ER (Extended release)100 mg (milligrams) 2 capsules (200mg) at 8 AM and 8 PM for seizures. A blood level for this medication was drawn every 2 weeks and the results reported on 2/29/12	F 333	(a) Identifying other residents having the potential to be affected ***Item # 1*** Resident R # 63 was not negatively impacted as a result of missing his scheduled dose of lantus. Once we were notified regarding the incident, corrective action was immediately taken. A one on one refresher in-service on standard of nursing practice and medication administration was completed on 10/12/12 *(See* Attachment H ***Item # 2*** Resident # 69 was not negatively impacted by the deficient practice cited. However, upon notification of incident, corrective action was immediately taken by initiating a medication error review and the facility medication administration policy on 10/10/12 (See Attachment H A one on one focus training with E7 regarding administering medication an hour before and an hour after scheduled dose was completed by DON on 11/09/12 (See Attachment). b) Identify other Residents having the Potential to be affected All residents have the potential to be affected by these deficient practices. (c) Systemic Changes Beginning 11/13/12 through 11/30/12, staff educators will conduct refresher in-service on medication administration with emphasis on new medication administration guidelines Training will also focus on documentation on the MAR (medication administration record), and current practice in medication administration. All new hires will receive training and competency on medication administration prior to completion or orientation. The Nursing QI team, Unit Managers, and Nursing Supervisors or designee will continue to monitor medication administration procedures. The Medication Administration Observation Audit Tool will be used to document observations (See Attachment I	10/10/12 10/12/12 11/30/12

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F 333	Continued From page 60 stated the Dilantin level was within therapeutic range. Review of the MAR (Medication Administration Record) lacked evidence that R69 had received the 3/1/12 8:00 AM dose of Phenytoin for his seizure disorder. During an interview on 10/9/12 at 2:20 PM, E3 (Director Of Nursing) acknowledged that R69's Phenytoin medication was not administered as per the physician's order and the facility's policy allows the nurse one hour before to one hour after the administration time to be given and still be considered as administered on time. E3 agreed the nurse could have circled her initials to indicate that the Phenytoin was not administered at 8.AM and/or obtained further orders from the physician to be given later when R69 awoke. E3 acknowledged that the nurse should have followed up. During an interview on 10/10/12 at 11:30 AM, E7 (nurse) confirmed that she failed to administer Phenytoin to R69 as ordered on 3/1/12.	F 333	(d) Monitoring Audit results will be reviewed by the Nursing Quality Improvement team at their monthly meetings. Summary of corrective actions will be forwarded to DON and QA to determine if further intervention is necessary.	11/30/12 and Ongoing
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on resident interviews and test tray	F 364		

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F 364	Continued From page 61 results, it was determined that the facility failed to provide food that was palatable. Additionally, one (R41) out of 39 Stage 2 sampled residents stated that the food was not palatable on two occasions. Findings include: 1. On 10/8/12 at 12:11 PM a test tray was sampled on the third floor for temperature and palatability. The test tray was delivered on the second meal cart and after all residents received their trays and began eating, the test tray was sampled for temperatures and flavor and palatability. The food temperatures were as follows: roast turkey open faced sandwich=139.2 degrees Fahrenheit (F); mashed potatoes=154.2 F; spinach=154.0 F. There were no beverages served on the test tray. Although the temperatures were found to be adequate, the mashed potatoes and spinach were bland and unpalatable. 2. On 10/8/12 at 12:10 PM, a test tray was sampled on the third floor for palatability. The test tray was delivered on the second meal cart and after all residents received their trays and began eating, the pureed test tray was sampled for temperatures and flavor and palatability. The pureed tray had gravy/biscuit = 132.9 degrees Fahrenheit (F) but was missing the turkey so there was no protein for this meal related to nutritive value. The mashed potatoes with gravy = 140.5 degrees F and the pureed	F 364 (a) Immediate Correction Action	Food Service Director interviewed five residents regarding satisfaction with identified food items listed in deficiency to identify improvement needed. Review of the items identified notated as "not palatable": Spinach, Mash potatoes, spaghetti, and rice were standard ordered items. Multiple cooks responsible for cooking various meals noted was found to affect the outcome. Gravy ordered through vendor Karates was found to be a substandard substitute accepted by the facility due to shortage of product actually ordered.	11/2/12
		(b) Identifying other Residents having potential to be affected	All residents have the potential to be affected by the palatability of food as it is such a subjective item.	
		(c) Systemic Response	All cooks were in serviced and trained on the use of standardized recipes that have been tested and approved by the LTC section. A policy on standardized recipe use was developed and reviewed with cooks. (see attachment) Salt substitutes and seasoning packets will be offered for items per the resident's request. New menu items are currently being tested and a new menu selection is due to be initiated. Improve food quality with vendor. Karates has been reported to OMB regarding unsatisfactory substitutions of product and numerous back orders as the incident occurs. (See attached report)	11/19/12

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F 364	Continued From page 62 spinach = 131.2 F which was warm. The gravy was very salty and not palatable. 3.On 10/01/12 at 11:07 AM in an interview, R41 stated that he was a cook and could "cook a lot better than that." The spaghetti is "No good." On 10/10/12 at 12:10 PM during an interview, R41 was observed having a steak sandwich and rice for lunch. R41 stated that he did not like the rice today, it "tasted bad". R41 agreed to have the information about the spaghetti and rice as examples in food quality issues. The facility failed to provide food that was palatable.	F 364 (d) Monitoring	Food Service Director and Cook Supervisor's will monitor food preparations to ensure standardized recipe use. Dietician Assistant meets quarterly with residents and will review and documents each resident likes and dislikes. (see attachment). Any deficient practices by the cooks will be monitored by the Food Service Director, who will take action with the employee's) involved.	11/12/12
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made in the dietary department and staff interviews, it was determined that the facility failed to prepare, serve, and distribute food under sanitary conditions to prevent the outbreak of food borne illness. Findings include:	F 371		

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F 371	Continued From page 63 1. Observation of the kitchen area on 10/1/12 at approximately 7:45 AM with E23 (Food Service Director) and E37 (Dietary Aide) revealed a scoop stored inside the flour, thickener and sugar bins that were touching and contaminating the food. 2. Observation of the kitchen area on 10/1/12 at approximately 7:55 AM with E23 (Food Service Director) revealed a gap between the drain pipe from the vegetable/food sink and the floor drain that was not properly sized, or at least twice the diameter of the water inlet required by the Delaware 2011 Food Codes. 3. Observations of refrigerators and freezers in the kitchen area on 10/1/12 at approximately 8:15 AM with E23 (Food Service Director) and E37 (Dietary Aide) revealed undated and unlabelled food as follows: a. Continental Prep refrigerator by 3-Compartment sink: - Two (2) packages opened yellow cheese and cold cuts lacked a date when the cheese was opened. - One (1) un-opened package of Whipped Cream Topping was observed without a date when the package was taken out of the original box (or container) when shipped to the facility. b. True Reach-in Refrigerator on 10/1/12 at approximately 8:25 AM: - Five (5) unopened bags of whipped topping lacked the date when the bags were taken out of the original packet and placed in the refrigerator. In an interview with E23 on 10/1/12 at 8:25 AM, he revealed that they should had been labelled unless they could refer to the box.	F 371	#1 a) Immediate Corrective Action (b) Identifying other Residents having potential to be affected c) Systemic Response (d) Monitoring	Food Scoops immediately removed, and hooks attached to food bins Dietary staff immediately discontinued the practice of putting food scoops inside of bins after use. Staff directed as of finding not to store scoops in the bins. Signage that states "Do Not Leave Scoops in Food Bins" has been fixed in the food bin area. All residents have the potential to be affected by sanitation and cross contaminations that can occur in the kitchen area. All staff in serviced and trained on proper storage of food scoops and contamination. Policy developed to address proper storage of scoops and all stock items to prevent cross contamination in the kitchen. (See attached Food Storage Policy) Daily monitoring of bins/scoops by FSW and kitchen supervisors. Food Service Director and Cook Supervisor's will monitor dietary staff usage of the bins and scoops for appropriate practice. Any deficient practices will be recorded by the Food Service Director, who will take action with the employee(s) involved. Grand Rounds checklist updated to add this item.	10/2/12 11/9/12 10/2/12

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F 371	Continued From page 63 1. Observation of the kitchen area on 10/1/12 at approximately 7:45 AM with E23 (Food Service Director) and E37 (Dietary Aide) revealed a scoop stored inside the flour, thickener and sugar bins that were touching and contaminating the food. 2. Observation of the kitchen area on 10/1/12 at approximately 7:55 AM with E23 (Food Service Director) revealed a gap between the drain pipe from the vegetable/food sink and the floor drain that was not properly sized, or at least twice the diameter of the water inlet required by the Delaware 2011 Food Codes. 3. Observations of refrigerators and freezers in the kitchen area on 10/1/12 at approximately 8:15 AM with E23 (Food Service Director) and E37 (Dietary Aide) revealed undated and unlabelled food as follows: a. Continental Prep refrigerator by 3-Compartment sink: - Two (2) packages opened yellow cheese and cold cuts lacked a date when the cheese was opened. - One (1) un-opened package of Whipped Cream Topping was observed without a date when the package was taken out of the original box (or container) when shipped to the facility. b. True Reach-in Refrigerator on 10/1/12 at approximately 8:25 AM: - Five (5) unopened bags of whipped topping lacked the date when the bags were taken out of the original packet and placed in the refrigerator. In an interview with E23 on 10/1/12 at 8:25 AM, he revealed that they should had been labelled unless they could refer to the box.	F 371	#2 (a) Immediate Correction action (b) Identifying other Residents having potential to be affected (c) Systemic Response (d) Monitoring	Drain was modified to meet regulations All Residents have the potential to be affected by this deficiency. Any future repairs or modifications of drains require air gap to be maintained per code. Grand rounds will monitor to ensure all drains maintain requirements.	11/8/12 Ongoing 11/12/12 11/23/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Survey Completed date: 10/12/12

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F 371	Continued From page 63 1. Observation of the kitchen area on 10/1/12 at approximately 7:45 AM with E23 (Food Service Director) and E37 (Dietary Aide) revealed a scoop stored inside the flour, thickener and sugar bins that were touching and contaminating the food. 2. Observation of the kitchen area on 10/1/12 at approximately 7:55 AM with E23 (Food Service Director) revealed a gap between the drain pipe from the vegetable/food sink and the floor drain that was not properly sized, or at least twice the diameter of the water inlet required by the Delaware 2011 Food Codes. 3. Observations of refrigerators and freezers in the kitchen area on 10/1/12 at approximately 8:15 AM with E23 (Food Service Director) and E37 (Dietary Aide) revealed undated and unlabelled food as follows: a. Continental Prep refrigerator by 3-Compartment sink: - Two (2) packages opened yellow cheese and cold cuts lacked a date when the cheese was opened. - One (1) un-opened package of Whipped Cream Topping was observed without a date when the package was taken out of the original box (or container) when shipped to the facility. b. True Reach-in Refrigerator on 10/1/12 at approximately 8:25 AM: - Five (5) unopened bags of whipped topping lacked the date when the bags were taken out of the original packet and placed in the refrigerator. In an interview with E23 on 10/1/12 at 8:25 AM, he revealed that they should had been labelled unless they could refer to the box.	F 371 #3 (a) Immediate Correction Action (b) Identifying other Residents having potential to be fected	Inspected all refrigeration units and food storage areas and disposed of any/all undated items. All residents who receive food have the potential to consume an item that was not labeled and dated.	10/2/12

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F 371	Continued From page 64 c. 2nd Continental Reach-in Refrigerator on 10/1/12 at approximately 8:30 AM: - One (1) 8-oz container of milk chocolate dated 9/11/12 and another five (5) dated 9/28/12 were observed inside the refrigerator and were outdated. In an interview with E23 on 10/1/12 at 8:30 AM, he confirmed that they typically trashed the containers if they were past the due or used-by-date. d. Walk-in Refrigerator on 10/1/12 at approximately 8:35 AM: - Two (2) packages of tortilla shells that had been wrapped in plastic were unlabelled and undated. - One (1) opened bag of shredded low-moisture whole milk cheese was undated. In an interview with E23 on 10/1/12 at 8:35 AM, he stated that when bags of any food were opened, they were supposed to date them to indicate the date it was opened. e. Walk-in Freezer on 10/1/12 at approximately 8:40 AM: - Two (2) bags of frozen carrot vegetables were observed undated and uncovered. f. Walk-in Keyed Bally Freezer Outside the Kitchen on 10/1/12 at approximately 8:45 AM: - Two (2) bags of ground beef were undated and were not in their original container. No expiration or use-by-date were observed on the beef plastic bags. - One (1) bag of frozen shrimp had no date. g. Dry food storage area on 10/1/12 at approximately 8:50 AM: - 5 containers of Berks Best beef soup base (low	F 371	#3 continued **(c) Systemic Response** Revised and implemented a new Food Storage Policy. See attached policy. Staff trained on Proper labeling and dating of food items. Reminder signs posted thru-out dietary to remind staff of the importance of labeling and dating stock. **(d) Monitoring** The Food Service Director, Cook Supervisor and Sr. Food Service Workers will monitor daily all food items to ensure staff follows policy guidelines. The Food Service Director will address any of staff's non-compliance. Random spot checks will be used as a tool to monitor overall compliance.	11/13/12 11/13/12

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F 371	Continued From page 65 sodium) were undated. The containers had a lot number (lot 212016). In an interview with E23 on 10/1/12 at 8:50 AM, he was unaware if the lot number was the expiration date. On 10/3/12 at 10:30 AM, E23 indicated that the food vendor was contacted and the lot number was a date. 4. Observations of the kitchen area with E23 on 10/1/12 at approximately 8:20 AM revealed debris on the condiment rack area, debris inside the lids drawer below the condiment rack, and on other racks inside the kitchen. In an interview with E23 on 10/1/12 at 8:20 AM, he confirmed this finding. Debris was observed also on 10/1/12 at 8:30 AM on the 2nd Continental reach-in refrigerator bottom section of the rack. 5. Observation of the kitchen area on 10/1/12 at approximately 8:13 AM with E23 revealed a slice of pizza in cellophane and three lunches in a white container stored inside the True reach-in resident refrigerator. In an interview with E23 on 10/1/12 at 8:21 AM, he revealed that the staff was not supposed to be storing their food in this refrigerator. E23 was observed taking all the staff food out of the refrigerator and placed them on a counter/table in the kitchen. 6. Observation of the walk-in freezer in the kitchen area on 10/1/12 at approximately 8:40 AM revealed a chunk of ice on the floor of the freezer. In an interview with E23 on 10/1/12 at approximately 8:40 AM, he revealed that they've had this leak in the freezer for about a week and a half. 7. Observation of a low temperature dishwasher on 10/1/12 at 9:35 AM with E23 (Food Service	#4 F 371 (a) Immediate Corrective Action (b) Identifying other residents having the potential to be affected (c) Systemic Response (d) Monitoring	Contents of drawer were discarded; All areas identified were wiped down per protocol. All residents have the potential to be affected by un-sanitized conditions in the kitchen Specific areas in the kitchen will be assigned to a specific individual daily per shift. In-service completed to review cleaning practices and assignment completion. Cook Supervisor will monitor the cleanliness of the kitchen area daily multiple times throughout day. The Sr. Food Service Workers will also monitor the completion of assignments daily per shift. Any deficient practices will be reported directly to Food Service Director, who will record the incident and address the staff person responsible. Food Service Director to complete periodic observation resident refrigeration units to ensure compliance. Grand rounds completed monthly will add this item to its checklist for further monitoring.	10/1/12 11/9/12 11/9/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

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F 371	Continued From page 66 Director) and E25 (Physical Plant Superintendent) revealed that the concentration of the chlorine sanitizer tested was measured with a test strip at a level from 25 to 50 PPM, but below 50 PPM. The color on the test strip was observed as a clear faint green color, rather than a very dark green color as indicated on the test strip chart for a 50 PPM chlorine concentration. Additionally, the test strip bottle used to test the concentration of the chlorine was stored on the wall across the dishwasher uncovered. In an interview with E23 on 10/1/12 at 9:35 AM, he stated that the chlorine level was supposed to be at 50 PPM (or higher) and he would contact the chemical vendor. E23 indicated that although the test strip indicated levels below 50 PPM based on the color of the strip observed, he stated this level was 50 PPM. In another interview with E23 on 10/2/12 at 9:20AM, E23 revealed the Chemical vendor had changed the test strips on 10/1/12 and they were able to see more clearly the correct concentration of the chlorine. E23 stated he was unaware the test strips had an expiration date and that leaving the test strips uncovered could result in them picking up moisture and not accurately reading the chlorine concentration. 8. Review of temperature logs for the 2nd floor and 3rd floor refrigerators indicated that the temperature was recorded as 40 degrees Fahrenheit (F) from 10/10/12 through 10/12/12. Observation of the 3rd floor nutrition room (300F) refrigerator on 10/10/12 at 11:25 AM revealed	F 371 #5 Continued (d) Monitoring	Cook Supervisor will monitor all resident refrigeration to ensure employee's non-use daily. The Sr. Food Service Workers will also monitor the resident's food storage areas to ensure staff's compliance daily. Any deficient practices will be reported directly to Food Service Director, who will record the incident and follow up with staff responsible. Food Service Director to complete periodic observation resident refrigeration units to ensure compliance. Grand rounds completed monthly will add this item to its checklist for further monitoring.	11/96/12

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F 371	Continued From page 67 one (1) Hypoint half-pint skim milk container. The milk was tested and found stored at a temperature of 47.3 degrees Fahrenheit (should be at or below 41 degrees F). This was confirmed by E16 (CNA) at that time. On 10/10/12 at 11:40 AM, the 2nd floor nutrition room refrigerator revealed one (1) Hypoint half-pint skim milk container. The milk was tested and found stored at a temperature of 44.8 degrees F (above 41). This was confirmed by E26 (Custodian) at that time. Observation of the 3rd floor nutrition room (300F) refrigerator on 10/11/12 at 7:50 AM revealed that the magnetic strip (black strip) was sticking out one (1) foot from the door seal. On 10/11/12 at 8:15 AM, E45 (Unit Clerk) confirmed the finding and stated that it was a new seal on the refrigerator. She then pushed the magnetic strip back into the door seal. On 10/11/12 at 9:08 AM, the 3rd floor nutrition room (300F) refrigerator revealed one (1) Hypoint half-pint reduced fat milk container stored at 49.1 F. On 10/11/12 at 9:10 AM, E20 (CNA) confirmed the finding. On 10/11/12 at 9:45 AM, E25 (Physical Plant Superintendent) stated that he was unaware of the refrigerator door seal issue. E25 stated that previously he replaced the gasket (door seal) on 8/22/12 and also on 9/18/12. On 10/11/12 at 1:25 PM, E25 stated that the refrigerator in the 3rd floor nutrition room was leaking cold air into the room.	#7 F 371 (a) Immediate Corrective Action (b) Identifying Other residents having the potential to be affected (c) Systemic Response (d) Monitoring	Sanitizer test strips that were expired or not properly sealed were located and immediately discarded. New test strips were supplied by chemical company and put into use. The test strips that we now use, more accurately display sanitizer's PPM. Entire Dietary staff in-serviced/trained on proper test strip usage and storage. All Residents have the potential to be affected by this deficiency if proper sanitation levels are not maintained. PPM will be monitored 3 times a day by FSW per protocol. PPM levels will be adjusted immediately. Monthly inventory of test strips levels to ensure continuous rotation of stock and expiration date monitoring will be completed. All staff trained on the new sanitation strips. Annual in-service will be scheduled and as needed trainings scheduled due to product changes. (See attached sanitizer tests strips policy. Cook Supervisor will monitor the log and test the sanitizers PPM once a week to ensure proper log information. The Sr. Food Service Workers will also monitor the completion and accuracy of the log. Any deficient practices will be reported directly to Food Service Director, who will record the incident and address the staff person responsible. Food Service Director to complete periodic sampling and observe staff testing process.	10/2/12 10/2/12 11/9/12 11/9/12 11/13/12
F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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F 428	483.60(c) DRUG REGIMEN REVIEW, REPORT	F 428		

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Barnabas' 428	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

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F 428 SS=D	Continued From page 68 IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that the consultant pharmacist identified the indication for a gradual dose reduction (GDR) for the antipsychotic medication, Seroquel during the medication regimen review (MRR) and failed to report it to the attending Physician and Director of Nursing for one (R14) out of 39 Stage 2 sampled residents. Findings include: Cross refer F329, example 4b R14 had diagnoses including hypertension, Organic Brain Syndrome (Multi infarct dementia with Psychotic features) and chronic Anxiety Syndrome. The psychiatric consult, dated 2/20/11, noted R14 had major depression with psychotic features. The MRRs were done monthly from 1/17/12 - 9/25/12 with "no changes" noted and action noted as "none".	F 428 (a) Identifying other residents having the potential to be affected b) Identify other Residents having the Potential to be affected (c) Systemic Changes	R # 14 was not negatively impacted by the deficient practice cited. Upon notification of incident, corrective action was immediately taken by obtaining psychiatrist consultation and initiating GDR for the use of the antipsychotic medication on 11/07/12. (See Attachment M) All residents on Antipsychotic medications have the potential to be affected by the deficient practice. The consultant pharmacist will recommend GDR (gradual dose reduction) to the primary care physician when appropriate after each quarterly review. GDR will be attempted quarterly unless clinically contraindicated. The pharmacist will participate in the interdisciplinary quarterly review of residents on psychoactive medications. All Licensed Staff will be in-serviced on the new Psychotropic / Psychoactive Medication Policy by staff development by 11/30/12. Emphasis will be on GDR (gradual dose reduction), non-pharmacological approaches and monitoring. The IDCC team will meet weekly to discuss residents on psychotropic / psychoactive medications and consider a GDR. Pharmacy consultant and NQI Nurse will work along with Primary Health Care physician in monitoring the GDR program. (See attachment L)	11/10/12 12/15/12

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F 428	Continued From page 69 The Physician's Order Sheets from 2/11 through 8/12 revealed that R14 physician's orders to continue at the same dose of the antipsychotic medication, Seroquel 150 mg twice a day. The facility failed to ensure that the consultant pharmacist identified the indication for a GDR related to the antipsychotic medication, Seroquel. On 10/12/12 at 11 AM in an interview, E3 (DON) confirmed the finding.	F 428	(d) Monitoring The Pharmacy Consultant will audit each resident medical record on a bi-annually basis and will report any irregularities to the attending physician, and the director of nursing. NQI nurse or designee will maintain a list of all residents on antipsychotic medication and will monitor recommended GDRs at each IDCC conference. Quarterly reports of GDR will be submitted to the Nursing Quality Improvement team at their monthly meetings. Summary of corrective actions will be forwarded to DON to determine if further intervention is necessary.	12/15/12 and ongoing
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the			

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F 428	Continued From page 69 The Physician's Order Sheets from 2/11 through 8/12 revealed that R14 physician's orders to continue at the same dose of the antipsychotic medication, Seroquel 150 mg twice a day. The facility failed to ensure that the consultant pharmacist identified the indication for a GDR related to the antipsychotic medication, Seroquel. On 10/12/12 at 11 AM in an interview, E3 (DON) confirmed the finding.	F 431	(a) Immediate Corrective Action ***Item # 1*** Upon notification of the incident, corrective action was immediately taken by disposing the two outdated vials of insulin. ***Item # 2*** Once informed regarding deficient practice, Unit Managers received reminders to check the medication room refrigerator daily for proper temperatures. A revised Temperature Check List was initiated on 11/15/12. **(See Attachment N)**	10/10/12
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	(b) Identifying other residents having the potential to be affected All residents have the potential to be affected by these deficient practices. (c) Systemic Response All licensee staff will be in-serviced on the revised medication policy. (See attachment) A new Medication Room and Refrigerator Temperature Check List was established on 11/15/12. Each day a nurse on the 3-11 shifts will be assigned to complete the Medication Room Temperature log ***(See Attachment N).*** (d) Monitoring Nurse Managers or designee will be responsible to monitor the medication room temperature to ensure consistency and proper temperatures. The NQI Nurse or designee will audit the temperature list. Audit results will be reviewed by Nursing Supervisors and the Nursing Quality Improvement team. Summary of corrective actions will be forwarded to the DON / ADON to determine if further intervention is necessary.	11/15/12 11/23/12

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F 431	Continued From page 70 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, it was determined that the facility failed to ensure all medications ready for administration were not expired and failed to consistently monitor the medication refrigerator for proper temperatures. Findings include: 1. On 10/2/12, a review of the facility's medication storage was completed. Observation with E8 (nurse) of the 2nd floor medication refrigerator revealed two (2) unopened vials of Humulin N (house stock) with expiration date of 09/2012. E8 confirmed that the insulin was expired and should have been discarded. 2. On 10/2/12 at 2:15 PM, review of the 2nd floor medication refrigerator temperature log revealed that there was no log for October 2012. Further review of the 2012 temperature logs revealed that the facility failed to monitor the refrigerator temperatures for June and September and had documented temperatures for only one day in April and 1 day in July. Documentation for all other months was incomplete. Findings were confirmed by E8 on 10/2/12 at 2:15 PM. During an interview on 10/2/12 at 2:40 PM, E5	F 431		

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F 431	Continued From page 71 (nurse/unit manager) stated that the 3-11 shift was responsible for completing the log book. The facility failed to consistently monitor the medication refrigerator temperatures on the 2nd floor and failed to have a system in place to ensure that temperatures were monitored daily.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		

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	085022	A. BUILDING _____ B. WING _____	C 10/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMILY P. BISSELL HOSPITAL	3000 NEWPORT GAP PIKE WILMINGTON, DE 19808

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F 441	Continued From page 72 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documents, and staff interviews, it was determined that the facility failed to maintain an Infection Control (IC) Program designed to help prevent the development and transmission of disease and infection. The facility failed to: 1. accurately code the infection incidents in weekly line listings reviewed, accurately analyze the monthly infection data for two (out of six) months, and the facility lacked documented evidence of corrective action taken on an ongoing basis (other than quarterly); and 2. failed to handle and process soiled linen and personal residents clothing (at the 3rd floor soiled utility room and the soiled areas of the personal laundry area) to prevent the spread of infection. Findings include: 1. Review of weekly line listings (entitled "Antibiotic line listing reports"), monthly "Infection/Site" analysis of infections report (from January 2012 to September 2012), quarterly infection data (entitled "New Facility-Acquired Infections: 2012"), and corrective action reports (entitled "Infection Control Committee Meeting") for the month and the year, revealed that the line listings lacked the location of infection sites consistently. The monthly "Infection/Site" analysis failed to accurately analyze the total number of	F 441 (a) Immediate Correction Action	***Item # 1*** Once the facility was notified about the discrepancies in the infection control data, Immediate corrective action was taken by correcting the weekly line listing and the monthly infections analysis reports for January and June of 2012. ***(E # 14)*** received reminders in regards to keeping accurate documentation including trends of infections, patterns, outbreaks, and clusters. **(See Attachment O)**	10/17/12
		(b) Identifying other Residents having potential to be affected	All residents have the potential to be affected by inaccurate documentation and inaccurate data collection.	10/25/12
		(c) Systemic Response	The Infection Control Nurse (ICN) will complete data analysis report of infections in the facility and will make weekly line listing report of infections. The Infection Control Committee will conduct monthly meetings to review line listing of infections and will identify specific organism for infections that are clinically indicated. The committee will investigate increases in the rate of infections with recommendations on what corrective actions to take in preventing the development and transmission of disease and infection.	11/12/12
		(d) Monitoring	Nursing Quality Improvement Nurse or designee will review the weekly line listing and monthly reports. Results will be brought to the monthly NQI meeting for review to ensure substantial compliance has been met.	11/30/12

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F 441	Continued From page 73 infections and infection rates calculated from the weekly line listing reports. Review of the infection analysis for January 2012 revealed a discrepancy between the weekly line listings of six infections and the monthly analysis report of four infections. Additionally in June 2012, there was a discrepancy between the weekly line listings of eleven infections and the monthly analysis report of eight infections. The infection analyses only reflected nosocomial infections and failed to identify the specific organism. In an interview with E14 (Infection Control Nurse) on 10/2/12 at 2:30 PM, she indicated that she calculated the infection rates each month and she did not take any corrective action if the infection rates were lower than 15%. E14 confirmed that the incident/infection data was not accurate and that she combined new acquired infections with old infections on the analysis report. E14 indicated that she analyzed the infection data quarterly and took the analyses to the quarterly IC team. The facility failed to maintain an accurate record of incidents, failed to analyze and investigate the increase in the rate of infections accurately, and failed to establish controls to prevent infections due to the incorrect or inaccurate data. The facility also lacked documented evidence of corrective action plans to control infections on an ongoing basis, such as weekly or monthly but only had the documented evidence for quarterly reviews of the IC data. In an interview with E44 (ADON) and E14 on 10/3/12 at 9:35 AM, they confirmed this finding.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 74 2a. The facility's Infection Control Policy, regarding Laundry entitled, "Maintenance of Infection Control procedure in Housekeeping for Nursing Units" was reviewed. Section 4 (Laundry) of the procedure documented that "Nursing will collect all resident soiled laundry specifically clothing, towels, washcloths, draw sheets, pull sheets, diapers ... Place in appropriate plastic bags and transfers to soiled utility room ...The Laundry Department provides laundering of all residents clothing who are unable to perform this area of ADL's" ...Section "CDC Guidelines, Linen/Clothing" documented that "soiled linen should be contained and bagged at the location of use...follow the healthcare facility's laundry procedures and use water temperatures and chemicals recommended by manufacturer .... ". The procedure lacked documentation on how to handle linen and transporting the linen from the wings to the laundry department. On 10/3/12 at approximately 9:10 AM, an observation of the residents' personal soiled laundry area in the basement with E27 (Laundry Staff)) revealed three piles of soiled personal linen on the floor in the washer area. Two of the large piles of soiled personal laundry on the floor were unbagged. The third pile on the floor had three bags of soiled personal linen of which two were in yellow bags which indicated linen on contact precautions. In an interview with E27 on 10/3/12 at 9:10 AM, she revealed she placed and sorted the residents' soiled personal laundry on the floor until she was ready to wash them. She stated that there was	F 441	#2b (a) Immediate Correction Action Policy updated to include Infection Control measures for transporting the linen and laundry from the unit to the basement. (See attachment) (b) Identifying other Residents having potential to be affected All Residents have the potential to be affected b this deficiency. (c) Systemic Response All clothing required to be bagged before leaving Resident rooms. Staff trained on procedure to ensure laundry and linen can be transported safely. Charge Nurse/Nursing Supervisor to observe and redirect daily. Grand Rounds checklist to include item. Laundry worker to report deficient practice to Hospital Administration. Infection Control Nurse will conduct observations and training on an ongoing basis. DON will document and follow up on any repeat offenders through disciplinary action. (d) Monitoring	11/23/12 11/23/12 11/26/12

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F 441	Continued From page 75 only one washer and the soiled linen was placed on the floor waiting to be washed. E27 confirmed that two yellow bags on the floor were soiled linen from residents on contact precautions. In an interview with E25 (Physical Plant Superintendent) on 10/3/12 at 9:28 AM, he confirmed this finding, and indicated that he would talk to E2 (Hospital Administrator) about this concern. On 10/3/12 at 1:21 PM, E2 acknowledged this finding. 2b. On 10/3/12 at approximately 9:10 AM, an observation of the basement hallway, outside of the personal laundry washer area, with E27 (Laundry Staff)) revealed two carts of unbagged personal soiled linen stored in the hallway that were covered but not kept under negative pressure. In an interview with E27 on 10/3/12 at 9:28 AM, she revealed she stored the carts of resident soiled personal laundry in the hallway after picking them up from the soiled area of the 2nd and 3rd floors. She stated that she stored the soiled linen from the carts outside in the hallway until she was ready to bring them inside to the washer area. Additionally on 10/3/12 at approximately 9:35 AM with E27, unbagged soiled linen on a cart inside the third floor soiled linen room was observed. In an interview with E27 on 10/3/12 at 9:35 AM, she confirmed this finding. The facility failed to handle soiled linen as to reduce the potential for infections.	F 441		
		(a) Immediate Correction Action	Sorting bins were available and placed in laundry room immediately upon surveyors reports of findings All clothing was removed from floor and placed in sorting bins Clothing bins stored in hallway were covered and moved to a storage room identified for dirty laundry Staff person responsible received a verbal warning for failure to follow standard of practice.	10/3/12 10/9/12
		(b) Identifying other Residents having potential to be affected	All Residents have the potential to be affected by this deficiency.	
		(c) Systemic Response	Policy developed identifying infection control protocols for Laundry processing (see attached). Performance Plan revised and reviewed with employee to include measurable goals and monitoring of performance.	11/23/12 11/23/12
F 465	483.70(h)	(d) Monitoring	Random weekly visits by supervisor to ensure protocols are followed	11/26/12

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F 465 SS=D	Continued From page 76 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation in the kitchen and interview on 10/1/12 at 7:40 AM, it was determined that the facility failed to provide a safe environment for staff in the kitchen area. Findings include: 1. On 10/1/12 at 7:40 AM an observation of the kitchen area with E23 (Food Service Director) and E37 (Dietary Aide) revealed that the hand sink hot water temperature measured 143 degrees Fahrenheit. Temperatures above 130 degrees can burn the skin. On 10/1/12 at 7:40 AM in an interview, E23 confirmed the finding.	F 465	(a) Immediate Correction Action: Sink placed out of order/alternate sink designated for hand washing. Faucets were replaced after finding cold water faucet was faulty. Sink water temperature was monitored 2 times a day for one week. Assessment of water pipes and mixing valve completed. (See invoice for new faucet)	11/5/12 10/19/12
			(b) Identifying other Residents having potential to be affected: No Resident has the potential to be affected by this deficiency; however it is a safety issue for staff.	
			(c) Systemic Response: Water pipes to be redirected from boiler supplying 160 degree water to dishwasher to domestic boiler supplying all hand sinks in facility which delivers temperatures between 100 to 110 degrees. Maintenance staff to review temperature regulations and immediate intervention to address future occurrences.	11/23/12
F 467 SS=D	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was determined that the facility failed to maintain adequate ventilation as reflected by		(d) Monitoring: Dietary staff to report any variations through work order submission process. Maintenance maintains a daily water temperature log and will address any temperatures outside 110 – 110 degree range.	11/23/12

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F 467	Continued From page 77 malfunctioning exhaust vents in two resident bathrooms. Findings include: On 10/1/12 at approximately 10:30 AM, an observation was made of the ceiling vent in the shared bathroom adjoining resident rooms 311 and 312. It revealed the vent was not drawing air out of the bathroom, was non-functional. The bathroom was not exhibiting negative pressure. On 10/1/12 at 10:35 AM in an interview, E29 (Physical Plant Maintenance Mechanic) confirmed this finding. Additionally, on 10/9/12 at approximately 8:50 AM, the ceiling vent in the shared bathroom adjoining resident rooms 313 and 314 revealed the bathroom was not under negative pressure and the vent was non-functional. On 10/10/12 at 11 AM in an interview, E30 (Physical Plant Maintenance Foreman) stated that the 311/312 bathroom ceiling vent was weak and the vent damper in the 313/314 bathroom ceiling was in the closed position with the vent not functioning.	F 467	(a) Immediate Correction Action (b) Identifying other Residents having potential to be affected (c) Systemic Response (d) Monitoring	Rm. 311/312 vent was assessed by maintenance and found to have weak return. Duct cleaning was completed on 10.19/12. Vent rechecked and is fully functioning. Rooms 313/314 was assessed and found to be closed. Vent was opened and functioning properly. Vent was closed by contractor in the pre-testing process prior to surveyors visit. See attached diffuse and grill test sheet. All Residents have the potential to be affected by this deficiency. The scheduling duct cleaning and balancing was completed. Mechanics trained on air flow testing. Semi-annually airflow test duplicating surveyors process to be completed by maintenance. Any vents found not to be functioning will be repaired immediately.	11/18/12 10/10/12 11/8/12 11/13/12 11/26/12
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and			

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F 514	Continued From page 78 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to maintain clinical records for one (R69) out of 39 stage II sampled residents in accordance with accepted professional standards and practices that were complete and accurately documented. Findings include: Review of R69's February 2012 "Q (Every) 15 minutes Face Check Flow Sheet" revealed that E35 (CNA) documented that face checks were done every 30 minutes on 2/26/12 from 2400 (12 Midnight) through 6:30 AM (14 times). Review of the facility documentation entitled, "LOA (Leave of Absence)" form and a nurse's note, dated 2/25/12 and timed 11:20 AM indicated that R69 was out of the facility on pass with a family member from 2/25/12 at 10:30 AM and expected "... To return 2/27." During an interview on 10/9/12 at 1:40 PM, E2 (Hospital Administrator) confirmed that R69 returned to the facility on 2/26/12 at approximately 10 PM and acknowledged that E35 incorrectly documented 14 safety checks on the 11-7 shift. E2 stated that the resident was out on pass at the time.	F 514	(a) Immediate Correction Action: Upon notification of the deficient practice, E #35 received verbal counseling regarding falsification of documents. E # 35 was reminded about reading the flow sheet and accurately documenting care provided and not to chart on residents when care was not perform.	5/12/12
			(b) Identifying other Residents having potential to be affected: All residents have the potential to be affected by the deficient practice, when clinical records are incorrectly documented.	
			(c) Systemic Response: Operation Support Staff (OSS) or designee will audit the C.N.A Flow Sheet weekly to ensure that documentation is complete and accurate. All Certified Nursing Assistants will receive reminders regarding accurate documentation. The C.N.A Audit Flow Sheet Tool will be use to document results *(see* **Attachment P)**	12/15/12
			(d) Monitoring: Audit results will be reviewed by Unit Managers and Nursing Supervisors. Summary of corrective actions will be forwarded to DON / ADON to determine if further intervention or disciplinary action is necessary.	12/15/12 and ongoing

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Emily P. Bissell Hospital

DATE SURVEY COMPLETED: October 12, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from October 1, 2012 through October 12, 2012. The deficiencies contained in this report are based on observation, interviews and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 63. The Stage 2 sample totaled thirty-nine (39) residents which included a review of one (1) closed record.	
3201	**Skilled and Intermediate Care Nursing Facilities**	
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**	

Provider's Signature _____ Title HOSPITAL DIRECTOR Date 11-15-12

JOHN S. OPPENHEIMER NHA H10000388 DE

NAME OF FACILITY: Emily P. Bissell Hospital

DATE SURVEY COMPLETED: October 12, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Cross refer to the CMS 2567-L survey report date completed 10/12/12, F156, F157, F167, F223, F225, F241, F246, F248, F253, F278, F279, F280, F281, F309, F312, F329, F333, F364, F371, F428, F431, F441, F465, F467, and F514.	3201.1.2 Cross refer to POC Survey report date completed 10/12/12; F 156, F 157, F 167, F 223, F 225, F 241, F 246, F 248, F 253, F 278, F 279, F 280, F 281, F 309, F 312, F 329, F 333, F 364, F 371, F 428, F 431, F 441, F 465, F 467, AND F 514.
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the 2011 Delaware Food Code.** **This requirement was not met as evidenced by:** **Based on the dietary observations during the survey, it was determined that the facility failed to comply with sections: 2-401.11, 3-302.12, 3-304.12, 3-501.16, 3-501-17, 3-602.11, 4-302.14, 4-501.11, 5-202.11A, 5-501.15, 6-403.11 and 6-501.114 of the State of Delaware Food Code. Findings include:** **2-401.11 Eating, Drinking, or Using Tobacco.** **(A) Except as specified in ¶ (B) of this section, an EMPLOYEE shall eat, drink, or use any form of tobacco only in designated areas where the contamination of exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES; or other items needing protection can not result.** **(3) *Exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.*** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371,	3201.7.5 2-401.11 Cross refer to POC Survey report date completed 10/12/12; F371, Example 5.

NAME OF FACILITY: Emily P. Bissell Hospital **DATE SURVEY COMPLETED:** October 12, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Example 5. **3-302.12 Food Storage Containers, Identified with Common Name of Food. Except for containers holding FOOD that can be readily and unmistakably recognized such as dry pasta, working containers holding FOOD or FOOD ingredients that are removed from their original packages for use in the FOOD ESTABLISHMENT, such as cooking oils, flour, herbs, potato flakes, salt, spices, and sugar shall be identified with the common name of the FOOD.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 3d. **3-304.12 In-Use Utensils, Between-Use Storage.** **During pauses in FOOD preparation or dispensing, FOOD preparation and dispensing UTENSILS shall be stored:** **(A) Except as specified under ¶ (B) of this section, in the FOOD with their handles above the top of the FOOD and the container;** **(B) In FOOD that is not POTENTIALLY HAZARDOUS (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon;** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 1.	3-302.12 Cross refer to POC Survey report date completed 10/12/12; F 371, Example 3d. 3-304.12 Cross refer to POC survey report date completed 10/12/12; F 371, Example 1.

NAME OF FACILITY: Emily P. Bissell Hospital

DATE SURVEY COMPLETED: October 12, 2012

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	3-501.16 Potentially Hazardous Food (Time/Temperature Control for Safety Food), Hot and Cold Holding. **(A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be maintained:** **(1) At 57℃ (135℉) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54℃ (130oF) or above; or** **(2) At 5℃ (41℉) or less.** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 8. **3-501.17 Ready-to-Eat, Potentially Hazardous Food (Time/Temperature Control for Safety Food), Date Marking.** **(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (D) and (E) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5°C (41°F) or less for a maximum of 7 days.**	3-501.16 Cross refer to POC survey report date completed 10/12/12; F371, Example 8.

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	(B) Except as specified in ¶¶ (D) - (F) of this section, refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶(A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. (C) A refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) ingredient or a portion of a refrigerated, READY-TO-EAT, POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first prepared ingredient. (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last	

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	date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; **(3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section; or** **(4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request.** **(6) Shelf stable, dry fermented sausages, such as pepperoni and Genoa salami that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers, and which retain the original CASING on the product; and** **(7) Shelf stable salt-cured products such as prosciutto and Parma (ham) that are not labeled "Keep Refrigerated" as specified in 9 CFR 317 Labeling, marking devices, and containers.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 3. **3-602.11 Food Labels.** **(A) FOOD PACKAGED in a FOOD ESTABLISHMENT, shall be labeled as specified in LAW, including 21 CFR 101 - Food labeling, and 9 CFR 317**	3-501.17 Cross refer to POC survey report date completed 10/12/12; F371, Example 8.

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	Labeling, marking devices, and containers. (B) Label information shall include: (1) The common name of the FOOD, or absent a common name, an adequately descriptive identity statement; (2) If made from two or more ingredients, a list of ingredients in descending order of predominance by weight, including a declaration of artificial color or flavor and chemical preservatives, if contained in the FOOD; (4) The name and place of business of the manufacturer, packer, or distributor; and (5) The name of the FOOD source for each MAJOR FOOD ALLERGEN contained in the FOOD unless the FOOD source is already part of the common or usual name of the respective ingredient (Effective January 1, 2006). (6) Except as exempted in the Federal Food, Drug, and Cosmetic Act § 403(Q)(3) - (5), nutrition labeling as specified in 21 CFR 101 - Food Labeling and 9 CFR 317 Subpart B Nutrition Labeling. (C) Bulk FOOD that is available for CONSUMER self-dispensing shall be prominently labeled with the following information in plain view of the CONSUMER: (1) The manufacturer's or processor's label that was provided with the FOOD; or (2) A card, sign, or other method of notification that includes the information specified under Subparagraphs (B)(1), (2), and (5) of this section. This requirement was not met as evidenced by:	

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	Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 3.	3-602.11 Cross refer to POC survey Report date completed 10/12/12; F371, Example 3
	4-302.14 Sanitizing Solutions, Testing Devices. **A test kit or other device that accurately measures the concentration in MG/L of SANITIZING solutions shall be provided. Pf**	
	This requirement was not met as evidenced by:	
	Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 7.	4-302.14 Cross refer to POC Survey report date completed 10/12/12; F 371, Example 7.
	4-501.11 Good Repair and Proper Adjustment. **(A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2.** **(B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.**	
	Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Examples 6 and 9.	4-501.11 Cross refer to POC Survey report date completed 10/12/12; F 371, Examples 6 and 9
	5-202.11 Approved System and Cleanable Fixtures. **(A) A PLUMBING SYSTEM shall be designed, constructed, and installed according to LAW. P151**	
	According to the 2000 International Plumbing Code, Section 802.2.1 entitled Air Gap, "the air gap between the	

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	indirect waste pipe and the floor level rim of the waste receptor shall be a minimum of twice the effective opening of the indirect waste pipe. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 2. **5-501.15 Outside Receptacles.** **(A) Receptacles and waste handling units for REFUSE, recyclables, and returnables used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers.** **(B) Receptacles and waste handling units for REFUSE and recyclables such as an on-site compactor shall be installed so that accumulation of debris and insect and rodent attraction and harborage are minimized and effective cleaning is facilitated around and, if the unit is not installed flush with the base pad, under the unit.** **5-501.112 Outside Storage Prohibitions.** **(A) Except as specified in ¶ (B) of this section, REFUSE receptacles not meeting the requirements specified under ¶ 5-501.13(A) such as receptacles that are not rodent-resistant, unprotected plastic bags and paper bags, or baled units that contain materials with FOOD residue may not be stored outside.** **5-501.113 Covering Receptacles.** **Receptacles and waste handling units for REFUSE, recyclables, and**	5-202.11 Cross refer to POC Survey report date completed 10/12/12; F 371, Example 2

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	returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT. **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F372. **6-403.11 Designated Areas. (A) Areas designated for EMPLOYEES to eat, drink, and use tobacco shall be located so that FOOD, EQUIPMENT, LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES are protected from contamination.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 5. **6-501.114 Maintaining Premises, Unnecessary Items and Litter.** **The PREMISES shall be free of: (B) Litter.** **This requirement was not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed, 10/12/12, F371, Example 4. **16 Del. C., Chapter 11, Subchapter I, Section 1108. Posting of inspection summary and other information and public meetings. (a) Each facility shall prominently and conspicuously post for display in a**	5-501.15 5-501.112 5-501.113 Cross refer to POC Survey report date completed 10/12/12; F 372 6-403.11 Cross refer to POC Survey Report date completed 10/12/12; F371, Example 5. 6-501.114 Cross refer to POC Survey Report date completed 10/12/12; F 371, Example 4.

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	public area of the facility that is readily available to resident, employees and visitors the following: **(3) The most recent state survey report prepared by the Department of the most recent inspection report for the facility.** **(c) The compliance history information required to be maintained for public inspection by a facility under subsection (a)(6) of this section must be maintained in a well-lighted accessible location. The compliance history material must include all inspection reports produced for that facility during the preceding 3 year period. The information must be updated as each new inspection or other Department report is received by the facility.** **This requirement was not met as evidenced by:** Observations on 10/10/2012 at approximately 11 AM during a tour of Day Room on Main 3 and Main 2 revealed that the most recent state survey reports for the preceding 3 year period were not posted. In an interview with the Director of Nursing on 10/10/2012 at 11:10 AM, confirmed that the survey reports were not posted in the Day Rooms.	